The Fairfields Practice

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Fairfields Practice on 4 November 2014. The practice operates from the Mary Potter Centre, Gregory Boulevard, Hyson Green, Nottingham NG7 5HY.

This practice has an overall rating of good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people (including the recently retired); people living in vulnerable circumstances; and people experiencing poor mental health (including people with dementia).

- 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.
- The practice was positive in promoting good health and encouraging patients to lead healthier lifestyles. For example several GPs had been involved in recognised research projects (practice and cluster service designs for the entire population). This had led to heavy smokers having had spirometry to screen for chronic obstructive pulmonary disease (COPD). Earlier diagnosis supported patients to get the advice and treatment they needed to manage their health and wellbeing.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Staff recognised and respected the totality of patient's needs. There was a proactive approach to understanding the needs of different groups of patients and delivering care in a way that met those needs and promoted equality. For example the practice had made sure that interpreters had been present in the practice to assist patients whose first language was not English to complete the patient satisfaction surveys.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

The practice had a clear vision and strategy and all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and all staff felt supported by management and knew who to approach with issues.

The practice had a number of policies and procedures to govern activity and those we saw were all up to date. The governance systems in place were robust and ensured that all practice staff took responsibility for identifying, assessing and managing risks. The practice partners had a clear oversight of the performance of the practice and any risks as a result of these systems.

The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions, had received regular performance reviews and attended staff meetings and events.

The practice used research to drive improvements and enable all patients to benefit from new and better treatments. This research also had the potential to improve outcomes for their own patients. The practice was a CRN (Clinical Research Network) level 2 approved practice and a Royal College of General Practitioners (RCGP) Research Ready practice.

The clinical audits carried out at the practice enabled the clinicians to focus on specific health needs and evaluate the findings. This led to better health outcomes for patients.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

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

People with long term conditions

Good

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

There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice offered an in-house spirometry service for the diagnosis of COPD This allowed a quicker service and did not require the patient being referred to a secondary service for diagnosis.

Families, children and young people

Good

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

The practice used innovative ways to ensure that children were immunised appropriately. The practice nurses used a recognised internet site to verify and check the childhood immunisation programmes in other countries to ensure that they provided the correct immunisation to children coming from those countries.

This information allowed staff at the practice to encourage mothers from overseas to have their children immunised. As a result of the nurse's work in this area immunisation rates among families with children who were from overseas were higher than similar practices in the area.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example,

Summary of findings

children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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 practice used innovative ways to protect the health of working age patients. For example the practice provided an offer of PSA (prostate specific antigen) testing to high risk groups (over 50's) which led to improved care such as urology referral.

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

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 such as those with a learning disability. Those who were homeless or patients from the travelling community were coded on the electronic system to identify they may be living in potentially vulnerable circumstance.

The practice had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

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).

Most patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice signposted and referred patients experiencing poor mental health to talking therapies through the improving access to psychological therapies (IAPT) programme. This was in response to very high number of patients registered with the practice experiencing severe mental ill health.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 17 completed comment cards. They were all positive, expressing views that the practice offered an excellent service with high levels of satisfaction across the whole service. Several comment cards made reference to the prescription service, which patients felt worked very well.

The practice carried out a patient survey on an annual basis. The results of the national GP survey completed in June 2014 showed 91% of patients who responded found the receptionists helpful, 87% said the last GP they saw or spoke with was good at listening and 99% said they had confidence and trust in the last GP they saw or spoke with. The data we reviewed before our inspection identified that the practice had a large number of patients who did not have English as their first language. Interpreters had been present in the practice to assist patients whose first language was not English to complete the surveys.

We spoke with six patients during our inspection including three members of the Patient Participation Group (PPG). All six patients said they were satisfied with the care they received, and thought all of the staff at the practice were friendly, welcoming and caring.

The Fairfields Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included one GP and one specialist practice manager.

Background to The Fairfields Practice

The Fairfields Practice provides primary medical care services to approximately 6,600 patients. The practice is based the Hyson Green area of the city of Nottingham; it is an inner city practice based in a multicultural area with a diverse population. 31.4% of the population is British/ Mixed British, 17.4% Pakistani/ British Pakistani, 5.3% Caribbean, 4.7% Indian/British Indian, 4.6% Polish and the remaining 36.6% of the practice is made up of 47 separate ethnic groups. The practice has a high-turnover of patients and registers on average 70 new patients a month, many of the new patients are new to the area.

The practice is located in a purpose built building, which is accessible to patients with restricted mobility; the consulting rooms and waiting areas being at ground level. The practice is housed in the Mary Potter Centre which is a joint service centre with a range of local services. These include: City Council services, three local GP practices (including the Fairfields practice), a range of clinics, Nottingham City Homes and there are bookable community meeting spaces and public toilets, a pharmacy and a community café.

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

There are five GPs at the practice, all of whom are partners. There are four female GPs and one male GP. The practice is a training practice for doctors and there are two whole time equivalent doctors in training working at the practice. At the time of our inspection one of the GP partners was away on maternity leave and a locum GP was working five sessions per week to cover.

In addition the nursing team comprises of one practice nurse and one nurse prescriber. The clinical team are supported by the practice manager and an administrative team. Four of the five GP partners work part time, as a result there are three whole time equivalents working at the practice.

The Fairfield 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). In addition Nottingham has a number of walk in centres where patients can be seen when their practice is closed.

Why we carried out this inspection

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

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

quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before under our new inspection process and that was why we included them.

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. We carried out an announced visit on 4 November 2014. During our visit we spoke with eight members of staff (GPs, nursing staff and administration and reception staff) and spoke with six patients who used the service. We observed how people were being cared for and talked with patients We reviewed 17 comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. The practice had an accident book to record accidents that occurred to staff or patients. On reviewing the information we saw that there had been no accidents recorded since November 2013. This was confirmed by staff we spoke with.

Discussions with six patients at the practice identified that they had no concerns regarding safety issues.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The practice manager told us that significant events and all external safety alerts were discussed at the regular clinical meetings, these were prioritised, were a standing item on the agenda and fed into the rolling action log. This was evidenced during our inspection.

Prior to our inspection the practice sent us a summary of significant events that had occurred in the previous twelve months. The summary identified that 43 significant events had occurred since November 2013. A GP told us the practice had a very broad definition of significant events and an open no blame safety culture within the practice. They told us there was a strong drive among the staff to get things right. Minutes of meetings where significant events had been discussed showed that the significant events had been analysed and learning points had been highlighted. The pro-active approach to significant events demonstrated that the practice had learnt from the significant incidents and patient safety had improved as a result.

The practice had a rolling action log. This was a document that identified who would be responsible for any action following a significant event. Once the action had been completed this was recorded in the log. The rolling action log ensured that action was followed up.

Reliable safety systems and processes including safeguarding

Information received from the Nottingham City clinical commissioning group (CCG) identified that the practice was located in an area of high deprivation. Data provided by the practice identified that the numbers of children identified as being 'at risk' was higher than other similar practices in the area.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The staff we spoke with told us that the lead safeguarding GP was aware of vulnerable children and adults registered with the practice and records demonstrated good liaison with partner agencies such as the police and social services.

There was an identified lead GP for safeguarding responsible for managing and reviewing the risks to vulnerable children registered with the practice. The staff training records showed that all staff were trained in safeguarding of vulnerable adults and children to a level appropriate for their role. The records demonstrated that most staff had received updated training in safeguarding during 2014.

We spoke with three administrative staff who were able to explain some of the different types of abuse and knew what to do if they had safeguarding concerns. There were posters available containing safeguarding information for the staff. This was also available on the intranet (the practice's internal computer information system). We saw that contact numbers for the local authority safeguarding teams were available for all staff.

There was a monthly meeting to discuss all children who were identified as being at risk. The meetings were held with health visitors and where appropriate school nurses. Minutes of meetings were available, and we saw that the practice took measures to safeguard those at risk children in their care.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Six administrative staff had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. One example was in respect of aspirin. On review of the notes 28 patients were identified who were being prescribed aspirin for primary prevention of cardio-vascular disease (CVD). The practice had taken the decision to stop prescribing aspirin for patients who were taking it for primary prevention of CVD. This was due to the possible side effects based on their clinical knowledge and the available research.

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

The most recent complete year's data we reviewed indicated that the rates for childhood immunisation were in most cases over the target of 90%. Staff told us the practice had been taking action to improve immunisation rates which had resulted in an increase in the number of childhood immunisations. To help with the uptake the practice nurses used a recognised internet site to verify and check the childhood immunisation programmes in other countries to ensure that they provided the correct immunisation to children coming directly from those countries.

A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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.

The number older patients who had received the influenza and the pneumonia vaccinations were above the average for the CCG. The take up rate for the under 65's was below the CCG average, and the practice had an action plan in place to improve the take up of this vaccine.

Cleanliness & Infection Control

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

The practice had a lead for infection control. All staff received training about infection control specific to their role and most staff had received an annual update during 2014. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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. There was a policy to manage and treat needle stick injuries.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the

environment which can contaminate water systems in buildings). Staff we spoke with confirmed the landlord was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments.

They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The PAT testing was due for renewal on the day of our inspection, and we saw equipment being tested throughout the day. The PAT testers were calibrating equipment such as weighing scales and thermometers to ensure they were providing the correct readings. Records held at the practice were updated during the testing and calibration.

A visual check of equipment at the practice did not raise any concerns.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy identified that the practice would follow the principals and ethos of the Equality Act (2010) when recruiting new staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

We saw the staffing rota for the practice and this identified there were sufficient numbers of suitably qualified and experienced staff to meet the needs of the patients. We discussed staffing with the member of staff responsible for the allocation of staff. We saw how staff were allocated, and how planned and sudden shortages were anticipated and covered.

Monitoring Safety & Responding to Risk

We found there were systems to identify, assess and manage risks relating to the health, welfare and safety of patients and others. These included annual and monthly checks of the building and the environment which were carried out by the building's owners and the landlord. Medicines management, staffing, dealing with emergencies and equipment were risk assessed and audited on a regular basis. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings.

We saw a fire safety risk assessment for the practice. The records showed that the landlord was responsible for checking the fire alarm system and ensuring that the fire extinguishers had been tested. Records were available to show this had been completed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that most staff had received training in basic life support during May 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff knew the location of this equipment and records confirmed that it was checked regularly. Emergency equipment was shared between the three practices. It was held in a central location and checked weekly.

The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately. The practice's significant event action log ensured that action was recorded and tracked following a significant event.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia to be used if patients went into shock or where diabetic patients had dangerously low blood sugar levels. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice did not routinely hold stocks of controlled medicines, as this was not seen as necessary. The practice is located two miles from both the Queens Medical Centre (QMC) with access to the accident and emergency department. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage any medical emergency which included dialling 999 and calling an ambulance.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and the necessary actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to refer to. For example, staff contact details if there was a staff shortage. The building was owned and managed by landlords who were present on site. The landlord would contact the heating company if the heating system failed for example.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could easily outline the rationale for their approaches to treatment. They were familiar with current best practice such as National Institute for Health and Care Excellence (NICE) guidance and locally identified best practice. There were regular clinical meetings held which evidenced a team approach.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as chronic disease management and palliative care and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that there was an open approach among colleagues.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. Data received from the CCG indicated that the referral rates for patients to secondary care compared favourably with other practices in the local area.

All GPs we spoke with used national standards for the referral of suspected cancers which ensured that patients were seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example a clinical audit of the practice's cancer bowel screening had been completed and the rate had risen from 37% to 43%. A clinical audit to monitor patients on antipsychotics & ensuring appropriate clinical reason for the patient to be taking them had also been completed. This had resulted in all patients receiving these medicines being reviewed.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input and scheduling clinical reviews.

The practice showed us four clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example an audit of the screening for bowel cancer had seen an increase from 37% to 43% between August 2013 and March 2014.

Other examples included audits and clinical reviews to monitor the number of patients taking antipsychotic medicines, and ensuring there were appropriate clinical reason for the patients to be taking the medicines. All patients taking these medicines had a medicines review including the reasons for being prescribed the medicine as part of the audit.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an intrauterine contraceptive insertion audit. Following the audit, the GPs had encouraged sexually active female patients to consider this method of contraception. GPs maintained records showing how they had evaluated and documented the success of any changes.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 96.8% of patients with diabetes had been referred to and seen by a dietician in the previous twelve months. The practice met all the minimum standards for QOF in respect of patients who were diagnosed as having diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) and chronic heart disease.

Several GPs at the practice had led on recognised projects (practice and cluster service designs for the patient population.) They had a number of initiatives to meet the

Good

Are services effective?

(for example, treatment is effective)

specific needs of their patient population group. These included; facilitating providing open access for blood tests and proactive and opportunistic cervical cytology (smear tests to prevent cervical cancer) for those patients whose first language was not English. The practice was positive in promoting good health and encouraging patients to lead healthier lifestyles.

For example several GPs had been involved in recognised research projects (practice and cluster service designs for the entire population). This had led to heavy smokers having had spirometry to screen for chronic obstructive pulmonary disease (COPD). Earlier diagnosis supported patients to get the advice and treatment they needed to manage their health and wellbeing.

The practice offered an in-house spirometry service, a test that can help diagnose various lung conditions, most commonly chronic obstructive pulmonary disease (COPD). This allowed a quicker service and did not require the patient being referred to a secondary service such as the local hospital for diagnosis.

One of the GP partners was supporting service re-design. For example an obesity support worker had been appointed by the CCG to tackle health related issues with obese patients in the local area.

We saw evidence of two recent studies undertaken at the practice. These were Clinical Research Network studies into smoking cessation and pre-diabetes which had used evidence based approach to improve health outcomes for patients.

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

There was a protocol for repeat prescribing which was in line with national guidance. Using this policy staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They 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 practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support which the practice partners considered to be mandatory. We noted a good skill mix among the doctors with all five partners having additional diplomas in sexual and reproductive medicine, and one GP with a special interest in dermatology.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs and action plans were documented. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries and out-of-hours GP services both electronically and by post. 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 staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

Reception and administrative staff told us the results of blood tests were not shared with a patient until they had been reviewed by a GP. If an appointment was required for

Good

Are services effective?

(for example, treatment is effective)

further investigation or to discuss the results this would be arranged. All clinical information such as pathology results and letters were always screened, coded and actioned by GPs.

The practice was commissioned to provide a number of enhanced services and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, the community matron, and the integrated care co-ordinator. Discussions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

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

The practice manager was the chair of the local EMIS user group, which allowed the practice to be at the forefront of any developments with the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Policies at the practice highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice had a consent policy in place which provided guidance to staff when they gave care and treatment to patients. The consent policy made reference to the Gillick competency for assessing whether children under 16 were mature enough to make decisions without parental consent. This allowed professionals to demonstrate that they had checked a person's understanding of proposed treatment, and used a recognised tool to record the decision making process.

Health Promotion & Prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice's performance for cervical smear uptake was 80%, which was better than other practices in the CCG area. 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 annually. There was a named nurse responsible for following up patients who did not attend screening. 67.93% of the practice patients had received mammography screening, and 43.6% of patients had received bowel cancel screening which was above the performance of other practices in the CCG area. There was a system in place to follow up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for the last complete year indicated that the rates of immunisations was above average for the CCG for both two

Good

Are services effective?

(for example, treatment is effective)

and five year old children. The take up rate for the Measles, Mumps and Rubella vaccine (MMR) was 93.8% which was above the CCG average. There was a clear policy for following up non-attenders by the named practice nurse.

In addition the practice had recorded the number of emergency admissions to hospital by patients who had dementia. This was 0.004% which was lower than the national figure of 0.04%. Practice records indicated that 80.6% of diabetic patients had an annual eye check (retinal screening) and 94% had received a foot check, this was above the average for other practices' in the locality.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey dated June 2014 and a survey of patients undertaken by the practice's patient participation group (PPG) in March 2013.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. In addition 85% of patients who responded said the last GP they saw or spoke to was good at treating them with care and concern. 97% said they had confidence and trust in the last GP they saw or spoke to.

We received 17 completed comment cards and all of these were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with six patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The reception desk was shielded by glass partitions which helped keep patient information and conversations private.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 84% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that 86% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 89% of respondents to the Patient Participant Group survey said they were given enough time. 94% of patients who responded said their GP was good at explaining tests and treatments.

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

Notices in the patient waiting room and on told people how to access a number of support groups and organisations.

A GP told us that if families had experienced bereavement, their usual GP contacted them. For example a GP told us of a situation where they had entered into the diary for the GP to contact the bereaved family again three to four weeks after the bereavement. GPs said this was because experience had shown this was an appropriate time to

Good

Are services caring?

make contact. The GP said the phone call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The PPG survey highlighted that some patients wanted to book appointments on line but were unaware this was an option. As a result the practice staff had promoted the practice website to enable patients to access on-line services such as appointments and requesting repeat medicines. This action was taken in direct response to patient feedback and it demonstrated a commitment to ensure patients' views and preferences were central to how the practice delivered the service.

The patient survey showed some patients were not aware that a GP/nurse telephone call was available. This had been discussed in a staff meeting the minutes of which were seen. The practice had actively advertised this service to its patients. The 2013 survey indicated that more patients were aware of this option.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice served a multi-cultural inner city area of Nottingham with a diverse mix of patients with different needs. The practice had patients who had a learning disability, who were unemployed, and who were carers.

The practice had identified that patients spoke over 60 different languages. As a result there was access to online and telephone translation services. One GP spoke languages such as Hindi, Urdu, Kannada, Telugu and understood Punjabi. We saw that information was available in languages other than English. Staff told us the practice had always managed to overcome any language barrier either by using language line, a pre-booked interpreter or finding a common language.

Staff said the practice had provided equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. Interviews with GPs demonstrated that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

The premises were purpose built and designed to meet the needs of people with disabilities. The practice was at situated on the ground floor with level access throughout. There were toilet facilities suitable for patients with restricted mobility and wheelchair users.

Access to the service

Appointments were available from 08:00 am to 06:30 pm on weekdays except on Thursday when the practice closed at 1pm for training. On Wednesdays there were extended opening hours from 08:00 am to 08:00 pm. The practice's extended opening hours on Wednesdays was particularly useful to patients with work commitments. This was confirmed by comments on three of the feedback cards we received. And our interviews with patients from different patient population groups. Feedback indicated they never felt rushed when they saw the GP.

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

Longer appointments were available for people who needed them and those with long-term conditions. This included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: reception staff said they would send a message to a GP if a patient was noticeable deteriorating or distressed. This would mean the GP would see that patient sooner. The reception staff was able to give an example of when this had happened in practice. In addition the reception staff said that there were extra appointments available for medical emergencies.

Listening and learning from concerns & complaints

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

We saw that information was available to help patients understand the complaints system. There were leaflets available and the practice website signposted patients to information about making a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 21 complaints received in the last 12 months and found that in some cases these had been identified as a significant event and handled as such. The majority (16) had identified learning points and actions. We considered a random sample of five complaints and saw that these had been responded to in line with the complaints policy and in a timely manner.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. These values were clearly demonstrated during discussions with staff.

The practice had an ethos that put patients at the heart of everything it did. The Fairfield practice is a training practice, and there was evidence of shared learning at all levels of staff.

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

Governance Arrangements

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

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice held three monthly partner meetings to discuss any risks; the practice vision, development and strategy including all aspects of the business and clinical care delivered at the practice. The practice used a system for ensuring that all issues and risks were identified and followed up in a robust and timely way. This system was used by all members of staff and reflected all areas of practice activity, both clinical and non clinical. The minutes of these meetings we saw confirmed this.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the disciplinary procedures and management of sickness which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through its own internal annual patient satisfaction survey, complaints and information on the NHS choices website. We looked at the results of the annual patient survey and only 2% of patients had booked their appointment on line. We saw as a result of this the practice had promoted the on line booking service both in surgery and on the website.

The practice had an active patient participation group (PPG.) The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. The PPG included representatives from various population groups; including older people, people with long term conditions and working aged patients.

The PPG told us they were consulted about the design of the patient survey, though this was carried out by the practice staff. The PPG met at least once a year and also had a virtual group for patients who could not attend meetings. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any

Are services well-led?

Good

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

concerns or issues with colleagues and management. Three members of staff told us that the senior staff at the practice were open and staff were encouraged to share their views. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. A review of staff training records identified that the majority of staff had attended training such as: fire safety, equality and diversity, and infection control. The records showed that the training was current, and dates for update training had been identified. Staff who were missing essential training had new dates identified.

The practice was a GP training practice with a full-time doctor in training. The practice took full-time doctors in training on placements. In addition first and second year medical students came on placement from Nottingham University. The practice was a CRN (Clinical Research Network) level 2 approved practice and a Royal College of General Practitioners (RCGP) Research Ready practice.

One GP was the CRN Research Clinical lead, and a second GP was the educational supervisor for the F2 doctor in training at the practice. A third GP was the GP trainer for the registrars within the practice. A fourth GP was the senior editor and regularly wrote a monthly column in the RCGP InnovAiT journal provided to all GP specialty registrars. This allowed the practice to learn about and share best practice, to develop the service by using the results of research in order to ensure positive outcomes for patients.

The practice had completed reviews of significant events, including good news significant events which demonstrated effective diagnostics and positive patient outcomes. The management team shared these with staff at meetings to ensure the practice improved outcomes for patients and to celebrate success and effective care and treatment.

There were many examples of significant events which were all well documented and shared. These covered a range of issues from complaints to a prescribing error. Examples of good practice had been recorded for example management of microscopic haematuria (blood) found by a routine urine sample analysis. The practice records showed that all significant events were routinely checked against an action log to ensure compliance with identified actions for each significant event.