Clifton Medical 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Clifton Medical Practice on 24 November 2014. The practice is located at Clifton Cornerstone, Southchurch Drive, Clifton, Nottingham NG11 8EW.

This practice has an overall rating of good. We found the practice to be good in the five domains of safe, effective, caring, responsive and well-led. We found the practice provided good care to older people and families, children and young people, people with long-term conditions, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood their responsibilities to raise concerns and report accidents, incidents and near misses. Opportunities to learn from internal and external incidents were analysed and used to support improvement.
- Clifton Medical Practice had sound clinical systems in place to ensure effective service delivery. This included regular clinical meetings with records of the discussion and learning points. In addition the practice followed local and national guidelines and best practice such as National Institute for Health and Care Excellence (NICE) guidelines.
- Data from the national patient's survey showed that patients rated the practice as well or higher than other practices locally and nationally. For example patients spoke positively about their experiences of receiving care from their GP.
- The practice ensured that referrals were made to hospital or other services in a timely manner.
- There was a stated vision for the practice, and clear lines of accountability and leadership in place. Complaints and concerns were addressed and learning points were used by the staff to make improvements.

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 people safe. The practice had ensured that robust recruitment procedures had been followed.

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 the National Institute for Health and Care Excellence (NICE) and used it routinely. People'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 planned. All staff received yearly appraisals and personal development plans were in place. 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 as good or 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. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and 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. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported data showed 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 with a named GP 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.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, 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, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening 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 including those with a learning disability. It had carried out annual health checks for people with a learning disability. It also offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

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.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 14 completed comment cards. All 14 were positive, expressing views that the practice offered a good service with understanding, caring and compassionate staff. Three cards also contained negative comments with the negative comments about the appointments system. Information from the national patient survey dated July 2014 showed that 43% of 102 patients who responded said they found it easy to get through to the practice by telephone.

The practice had produced a patient satisfaction survey. The data collected related to the period 1 July 2014 to 30 September 2014 and showed that 28 patients had taken part. Comments were generally very positive, with 89.3% of respondents indicating they were satisfied with the care and treatment they received. There was an action plan on the practice's website.

We spoke with four patients during our inspection. All four patients said they were happy with the care they received, and thought all of the staff were friendly, welcoming and caring. Information from the national patient survey dated July 2014 indicated 88% of patients surveyed said the last appointment they got was convenient, 80% of those patients surveyed said the last GP they saw was good at treating them with care and concern. In addition 93% said they had confidence and trust in the last GP they saw. From the same national survey 55% of respondents described their experience of making an appointment as good.

Clifton 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 one GP and one specialist practice manager.

Background to Clifton Medical Practice

Clifton Medical Practice provides primary medical care services to approximately 8,000 patients. The practice is based in a building close to the centre of Clifton on the outskirts of the city of Nottingham.

The practice does not offer a dispensary service. However, patients can access medicines from an independent pharmacy located within the same building as the practice.

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 six GPs at the practice. There are four female GPs and one male GP. In addition, the nursing team comprises four practice nurses and three healthcare assistants. The clinical team are supported by the practice manager and an administrative team. None of the GPs work full time, as a result when fully staffed there are nearly four and a half whole time equivalent GPs working at the practice.

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

Why we carried out this inspection

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

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

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

Detailed findings

- 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 24 November 2014. During our visit we spoke with a range of staff (GPs, nursing staff and administration and reception staff) and spoke with patients who used the service. We observed how people were being cared for and talked with patients We reviewed 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, the practice maintained an accident book. The last reported accident was in 2012. Records showed this was dealt with appropriately. The practice also recorded significant incidents and reported incidents and used national patient safety alerts as well as comments and complaints received from patients to monitor safety issues. 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. The records were available for the last five years. These showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred over a number of years, although we only reviewed those from the last year. Significant events were a standing item at the weekly practice meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that findings were shared with relevant staff. The records of significant events also recorded action taken and what was learnt. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

The practice manager showed us the system she used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example following one incident a poster had been displayed indicating no photographs could be taken in the practice. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The records also showed just over half of the staff were up to date with their safeguarding vulnerable children training, and less than half were up to date with their safeguarding adults training. The practice manager told us steps were being taken to ensure staff were up to date with this training.

Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for making a safeguarding referral were readily available to all staff.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (eg level 3). All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. The practice had a safeguarding pack for locum GPs which included all of the relevant information and guidance.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Regular multi-disciplinary child protection meetings were held, and we were shown copies of minutes that had been anonymised to protect the patient's identity.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, 11 receptionists and administrative staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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Are services safe?

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 lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Patients or families were signposted to the local authority's Children's Service at Dovecote primary school if there was any evidence of risk. This service offered a drop in service twice a week, and advice and support.

Medicines Management

Medicines stored in the treatment rooms and medicine refrigerators and were stored securely and were only accessible to authorised staff. There was a 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. The practice used a system to ensure any power failure overnight or at the weekend was identified.

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. For example, an MHRA (Medicines and healthcare products regulatory agency) alert around the use of the medicine domperidone had been received by the practice. This prompted an audit of the use of this medicine. Every patient receiving this medicine had it reviewed, and either stopped, or the reason for continuance recorded.

The nurses and the health care assistant 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 and the health care assistant had received appropriate training to administer vaccines. 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.

We reviewed data related to childhood immunisations. The rates childhood immunisations (with the exception of the MMR (Measles, Mumps and Rubella) vaccine for children aged 24 months) the practice was higher than the CCG average. The MMR rates were only just below the CCG average.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness & 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 and close links with the local Community Trust's infection control team. Staff accessed infection control training and support through the Community Trust. All staff received induction training about infection control specific to their role and received annual updates. The last updates were on 5 February 2013 and had included a hand hygiene audit for all staff.

We saw evidence that the lead had carried out audits for each of the last three years 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 external infection control audit had been completed in July 2014 and the practice was working through the action plan to improve infection control outcomes for patients.

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in 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). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer. The practice maintained a spread sheet with all relevant information relating to maintenance and calibration. All equipment which required calibration had been checked and certificates issued during 2014.

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.

There were suitable arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also 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.

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

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of medicines management, staffing, dealing with emergencies and equipment. The practice was a tenant in the building, and health and safety checks to the environment were carried out by the landlord on a daily basis. The practice had its own 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. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support on 4 November 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). Members of staff knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency for a patient arising from an adverse reaction to a prescribed medicine. The practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. This included medicines for the treatment of cardiac arrest, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The plan had been updated in November 2014. Each risk was identified and the necessary actions were recorded to reduce and manage the risk. Risks

Good

Are services safe?

identified included power failure, adverse weather and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details for every member of staff.

The practice had carried out a fire risk assessment dated 11 October 2013, that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where updates were shared and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. Staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led on specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice had also completed a review of patients having a cervical smear which showed that where necessary a small number of patients had been recalled to have the procedure repeated. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data from July 2014 showed that the practice was performing well in relation to referral rates to secondary and other community care services for all conditions. Patients with suspected cancers were referred and seen within two weeks of seeing their GP. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and these evidenced that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed 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.

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, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us ten clinical audits that had been undertaken since December 2013. Six of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example there was an audit of patients with a diagnosis of gout (a medical condition characterised by acute inflammation of the joints usually in the foot.) The audit assessed the treatment and management of these patients against NICE guidelines and identified a number of changes were required to ensure that the practice followed best practice guidelines.

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, following a Medicines and Healthcare products Regulatory Agency (MHRA) safety alert patients receiving the medicine metoclopramide were audited. Metoclopramide is a medicine often used to treat nausea and vomiting. As a result patients were invited for an appointment, or the medicine was stopped where appropriate.

GPs maintained records showing how they had evaluated the service and documented the success of any changes. The practice had also carried out an audit cycle for the use of anti-psychotic medicines in patients with dementia. This had been completed by the lead GP for dementia, and following analysis of the data learning points had been shared throughout the practice.

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

Good

Are services effective?

(for example, treatment is effective)

programmes to monitor outcomes for patients. For example, 98.4% of patients with diabetes had an annual retinal screening, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff 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. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice's computer system flagged up medicines alerts when the GP was prescribing medicines. We saw that after receiving an alert, the GPs had reviewed the use of the medicine in question. Where they continued to prescribe the medicine the reason was recorded and they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice nurse told us about an internal peer review system staff participated in. This particularly focussed on referral rates and looked at ways of making improvements. Consideration was also given to NICE guidelines for skin cancer referrals and eczema treatment, and the solar keratosis primary care pathway. Solar keratosis is a pre-cancerous patch of thick, scaly or crusty skin. The practice had also taken part in an external peer review with two other local practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement. For example in the area of commissioning new services.

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

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to or better than other services 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 important courses such as annual basic life support. We noted a good skill mix among the doctors with four having diplomas in sexual and reproductive medicine, and five with diplomas in children's health and/ or obstetrics. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example all of the nursing staff including the healthcare assistants had attended training about anaphylaxis (adverse allergic reaction) and the qualified nurses had attended training about vaccination and immunisation.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and support patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services 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.

Good

Are services effective?

(for example, treatment is effective)

The practice was commissioned for the new enhanced service 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). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings with varying degrees of frequency from monthly to quarterly. These meetings were to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. We saw minutes of meetings to confirm the frequency and attendance of other health and social care professionals. Staff felt this system worked well and told us about the usefulness of the forum as a means of sharing important information.

For mothers and young children the practice had a designated midwife who was based in the same building. If the designated midwife was unavailable there was a midwife 'hot line' so that the practice could speak to a midwife to get advice. This was particularly useful in an emergency situation where it was important to speak to a midwife quickly.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system called Adastra with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system to give patients choice. (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.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency (A&E). One GP highlighted the importance of this communication with A&E.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (2005), the Children Acts (1989) and (2004) and their duties in fulfilling it. The staff training records showed that staff had not completed training in the Mental Capacity Act (2005). However this training had been identified as being needed, and plans were in place for staff to receive the training. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had drawn up a policy to help staff understand the law by providing some specific scenarios where capacity to make decisions was an issue for a patient, for example with making do not attempt cardio pulmonary resuscitation (DNACPR) orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved where possible in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

A GP said that the number of patients with dementia had been growing steadily within the practice as patients were living longer. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Good

Are services effective?

(for example, treatment is effective)

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

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. 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 opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and had identified 39 patients. All of the patients with a learning disability were offered an annual physical health check.

The practice had identified the smoking status of patients over the age of 16 and actively offered a referral to New Leaf for specialist advice and support with smoking cessation. The New Leaf service was also based in the same building as the practice, which made referral quick and easy for the patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Many of the community based health services in the area were based in the same building, which made access easier for patients. For example the practice worked closely with the community nutrition and dietetic service, as many of the elderly patients at the practice were receiving dietary supplements. NICE guidelines identified that patients should only receive dietary supplements on a regular or long term basis if they have been assessed by a dietician. We saw that contact with the dietician was via a task on SystmOne, which made the process quicker.

The practice made referrals to the falls and rehabilitation team. Patients were assessed in their own home and the practice staff were involved in a weekly falls clinic in the building.

The practice's performance for the uptake of cervical smear screening was comparable with others 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.

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 all immunisations the practice was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

A range of health services were available through the practice website. For example there was a link to free chlamydia testing, there was also information regarding relationships and sexual health and C Card information, which provided sex education and condoms for safe sex. The website also provided information on long term conditions and information and support for carers.

The practice had made referrals in the past to the children and adolescent mental health service (CAMHS) in Nottingham. A GP said the practice would be attending the launch of the universal pathway for children and young people with behavioural, emotional or mental health needs in Nottingham city. This was due to be launched in December 2014. The GP said that Nottingham had good services within the city for children with mental health needs, and that support and advice was available through CAMHS.

The practice also had details of the special needs dental service which was aimed at patients who had a learning disability, severe health problems, very young children with severe dental decay and very nervous children. A GP said that they had referred to this service in the past.

Good

Are services effective?

(for example, treatment is effective)

The practice's data showed that 92.6% of patients with a diagnosis of diabetes had received an annual foot check. A further 98.4% of those patients had received an annual eye check and 93.3% had discussed their diet with a dietician as part of their annual review.

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 July 2014, and a survey of 28 patients undertaken by the practice's patient participation group (PPG) between July and September 2014. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed 84% of patients who responded to the survey rated the practice 'among the best.' The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 88% of practice respondents saying the GP was good at listening to them and 81% saying the GP gave them enough time.

However, the practice could make better use of the PPG patient survey. This had only been completed by 28 patients which was not representative of the practice population. The recorded data did not inform the reader about the quality of services or areas for improvement.

We received 14 completed cards from patients and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive, saying that getting an appointment could be difficult, although all three said once they had an appointment the GP or nurse they saw was very good. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us 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 practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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. We were shown an example of a report on a recent incident that showed the actions taken had been robust. There was also evidence of learning taking place as staff meeting minutes showed this had been discussed.

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 72% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results.

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

Staff told us 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.

Good

Are services caring?

Discussions with a GP highlighted that older patients (aged 75 and above) had care plans in place and patients had been involved in agreeing these. This was supported by two older patients we spoke with about the care they were receiving.

Patient/carer support to cope emotionally with care and treatment

During our inspection we saw different leaflets and posters in the waiting area signposting patients to additional support services. This included leaflets from agencies supporting people with mental health needs or those who were victims of domestic violence. There were information leaflets about the 'health shop' which is a drop in centre for sexual health and substance misuse. Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations.

Feedback we received showed patients felt well supported. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. The practice's computer system alerted GPs if a patient was a carer. There was written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This 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. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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 NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. Practice staff told us there were a higher than average number of older patients registered at the practice which was supported by data we saw. Every patient over the age of 75 had a named GP, and the practice had fostered close working links with the community nutrition and dietetic service, the falls and rehabilitation service and the memory clinic.

Information from the national patient survey dated July 2014 showed that 43% of 102 patients who responded said they found it easy to get through to the practice by telephone. We spoke with four patients during our inspection. All four patients said they were happy with the care they received, and thought all of the staff were friendly, welcoming and caring. Information from the national patient survey indicated 88% of patients surveyed said the last appointment they got was convenient, 80% of those patients surveyed said the last GP they saw was good at treating them with care and concern. In addition 93% said they had confidence and trust in the last GP they saw. From the same national survey 55% of respondents described their experience of making an appointment as good.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had patients from across all of the population groups including those whose circumstances made them vulnerable and those who may struggle to access GP services.

The practice had access to online and telephone translation services. Information about translation services was available in the waiting room and at the reception desk. The practice had low numbers of patients whose first language was not English. As a result demand for translation services were rarely required. One member of staff said that there were a few patients whose first language was not English. The practice had used a Polish speaking interpreter in the past. The practice gave an example of a patient who had been given extra time for their appointment. Afterwards staff said the patient had said they were satisfied with their appointment.

The practice provided equality and diversity training every two to three years. The staff training records showed that 12 members of staff had completed this training, although refresher training was due. Discussions with staff and comments from patients both on the day and on comment cards identified that staff had an understanding of issues related to equality and diversity.

The premises and services had been adapted to meet the needs of people with disabilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8:30 am to 6:30 pm on weekdays. Reception staff said that on occasions patients would attend the surgery without an appointment. In these circumstances patients would always be seen, although they might have to wait some time to be seen. Practice staff said the older patients were prepared to do this and a patient we spoke with confirmed this was the system in place.

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

Longer appointments were also available for people who needed them and those with long-term conditions. This

Good

Are services responsive to people's needs?

(for example, to feedback?)

also included appointments with a named GP or nurse. Home visits were made to local care homes, usually by a named GP. The GP took a laptop when visiting care homes which allowed access to the practice records, and ensured continuity of care.

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

Discussions with staff at the practice identified that older patients and people with long-term conditions could receive home visits where needed and longer appointments were also available.

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. Information was available on the website, although not easy to find. The practice had a leaflet detailing how to make a complaint; and copies of the leaflet were available in the waiting area. The leaflet set out the patient's options including contacting NHS England and the Health service Ombudsman, with contact details for both. 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 seven complaints received in the last 12 months and found these had been dealt with in a timely way, and there was openness and transparency in dealing with the complaint. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and saw three complaints related to access to the service, and patients not being able to get an appointment. The practice had set up a meeting with the company who managed the telephone system to look at ways of improving patient's telephone access.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were not displayed in the waiting areas; however they were recorded on the practice website. The practice vision and values included: "To provide a high level of patient care; To constantly strive to improve the services we offer; To engender an open, honest, non-threatening style of management where staff are encouraged to express their views and be involved and to make work as enjoyable as possible, whilst achieving along the way."

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 and all eight had been reviewed annually and were up to date. Most staff had completed a cover sheet to confirm that they had read the policy and when.

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 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 comparing the management of gout at Clifton Medical Practice to the NICE guidelines.

Leadership, openness and transparency

We saw from minutes that practice meetings were held regularly, at least monthly. Staff told us there was an open culture within the practice; they had the opportunity to ask questions 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 induction policy for administrative staff and the management of sickness which were in place to support staff.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual national patient survey dated July 2014. The data showed 43% of 102 patients who responded said they found it easy to get through to the practice by telephone. As a result the practice had set up a meeting with the telephone access company to look at ways of improving this.

The practice had an active patient participation group (PPG). 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 concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff 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.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to

Are services well-led?

Good

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

ensure the practice improved outcomes for patients. The practice had recorded 18 significant events during the past 12 months. These had been analysed and learning points from each identified and shared with staff.