

East Bridgford Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

On 25 August 2015, we carried out a comprehensive inspection of East Bridgford Medical Centre. The practice was rated as requires improvement overall and rated as inadequate for providing safe services, good for effective, caring and responsive services and requires improvement for well led services.

As a result of the findings on the day of the inspection the practice was issued with requirement notices for regulation 12 (Safe care and Treatment) and regulation 18 (Staffing).

Specifically we found that

There were systems and processes that were not sufficiently robust to ensure that patients were kept safe from harm. The storage and management of medicines did not meet the required standards and some staff had not received appropriate training to fulfil their role.

The practice sent us an action plan that outlined the steps they were taking to improve and we then carried out an announced comprehensive inspection of East Bridgford Medical Centre on 6 May 2016.

We undertook this inspection to check that they had followed their action plan to address the shortfalls and to confirm that they now met legal requirements.

Our key findings across all the areas we inspected were as follows:

- Improvements had been made that addressed the findings of our inspection on 25 August 2015. These included the proper and safe management of medicines, doing all that is reasonably practicable to mitigate any risks, and ensuring that staff received appropriate support and training.
- The appointment system was flexible and ensured that patients who requested to be seen on the same day were able to obtain an appointment.
- The practice had good facilities including access for those with limited mobility. A hearing loop was available for those patients who needed it. Patients that were particularly unwell were asked to wait in areas where reception staff could observe them, in case their condition changed.

Summary of findings

- Information about the services and how to complain was available. The practice sought patient views about improvements that could be made to the service and some of these discussions occurred through the patient participation group (PPG).
- The practice proactively managed care plans for vulnerable patients and had effective management strategies for patients at the end of their life. This enabled 78% of patients to die in their preferred place of care.
- There were systems, policies and procedures to keep patients safe and to govern activity for example, infection control.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.

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?

The practice is rated as good for providing safe services.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. There was a system in place for reporting and recording significant events. Learning was shared to make sure action was taken to improve care and safety in the practice.

The practice had arrangements in place to safeguard patients from abuse and ensure enough staff were on duty to keep people safe.

Appropriate recruitment checks had been carried out for staff including Disclosure and Barring Service (DBS) checks for those who acted as chaperones.

There were systems and processes in place for the safe management of medicines and these were well managed.

The practice had systems to identify and mitigate risks to staff and patients who used the service.

The practice had a robust business continuity plan in place to manage major incidents and emergency contact numbers had been included.

Good



Are services effective?

The practice is rated as good for providing effective services.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Data showed patient outcomes were often better when compared to other practices in the locality. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health.

Staff had received training appropriate to their roles; additional training requests were identified, and usually provided. There was evidence of appraisals and personal development plans for all staff.

Staff worked with multidisciplinary teams including community nurses, health visitors, a care co-ordinator, and a health trainer. The practice had 282 patients who had been identified as vulnerable and as a result of joint working, a written care plan was held in their medical records and 90% of the patients received an annual review. Joint working with community teams ensured that 78% of patients at the end of their lives died in their preferred place of care.

Good



Summary of findings

Are services caring?

The practice is rated as good for providing caring services.

The GP national patient survey data published in January 2016 showed that patients rated the practice above the national average in many aspects of care. For example 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.

Patients told us they were treated with compassion, dignity, respect and they were involved in care and treatment decisions. We saw that staff treated patients with kindness and respect and in a way that was individual to those patients that needed extra support. For example, the practice had a staff member who was a champion for carers support.

The practice had identified 1.5% of their patients as carers, including young carers and provided them with a carer's pack which gave information including details of support groups. In addition the Rushcliffe CCG had commissioned the Carers Federation and provided a bespoke service which was delivered in the practice.

The practice demonstrated that they prioritised patient centred care and confidentiality was maintained.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Practice staff described how they were aware of the needs of their practice population, and tailored their care and services accordingly.

The practice had developed flexible appointment systems for patients to access services, for example people experiencing poor mental health had access to GPs at a time that was convenient for them and without the need to book through the appointment system.

Telephone consultations and home visits were available for those that requested them.

Dispensary staff delivered medicines for patients who were housebound.

The premises were suitable for patients who had a disability or those with limited mobility.

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. The complaints received had been dealt with in a timely and appropriate manner.

Good



Summary of findings

A total of 98% of patients who completed the family and friends test would recommend the practice. This test asked patients whether they would recommend the GP practice to friends and family if they needed similar care and treatment.

Are services well-led?

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

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by the management team.

An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

The partners encouraged a culture of openness and honesty. The practice had systems in place for reporting safety incidents, investigating and taking action. Regular meetings were held to ensure shared learning. Staff told us they worked well together with the management team to improve on the areas of non-compliance identified at the previous inspection and they felt supported through the changes made.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

There was a strong culture on continuous education, learning, and improvement.

Good



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

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

The practice offered proactive, personalised care to meet the needs of the older people in its population. Home visits were available for those unable to attend the practice. Continuity of care was maintained for older people through a stable GP workforce and personalised patient centred care. The practice provided visits to local care homes.

The practice regularly reviewed attendances at the accident and emergency department to ensure patients identified as vulnerable to admission were reviewed.

Good



People with long term conditions

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

Nursing staff had roles in chronic disease management and data reviewed showed patient outcomes were similar when compared with other practices in the locality. Patients that had attended appointments had a structured annual review to check that their health and medication needs were being met.

The practice held regular meetings attended by GPs, nurse and administration staff to ensure that patients received appropriate re-calls and follow up for their long term conditions.

Home visits were available to those patients who could not attend the surgery.

Longer appointments were available if required. Practice staff followed up patients who did not attend their appointments by telephone.

Good



Families, children and young people

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 patients who had a high number of accident and emergency (A&E) attendances. Immunisation rates were in line with local averages for all standard childhood immunisations. Young children were given priority appointments for urgent needs.

Good



Summary of findings

The practice proactively offered routine contraceptive services and was a centre for the C-card scheme. This scheme provides young people with free condoms. The school nurse liaised directly with a GP when it was identified that a young person needed advice regarding their health and well-being.

Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice had identified five young carers and was proactive in supporting these young people.

We saw examples of joint working with midwives, health visitors, and school nurses.

Working age people (including those recently retired and students)

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, including 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 reflected the needs for this age group. Patients were able to book appointments at times that were convenient to them for their annual reviews. Telephone consultations were available for those patients who wished to seek advice from a GP.

NHS health checks were available and appropriate follow up arranged, promoting health prevention and healthy lifestyles.

The practice's uptake for cervical screening was above the CCG and national average. The percentage of patients who had been screened for breast and bowel cancer was above the CCG and national average.

Good



People whose circumstances may make them vulnerable

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 offered longer appointments and carried out annual health checks.

There were 30 patients on the register for patients with learning disabilities, 14 of these had received an annual review, and two had declined. We discussed this with the practice who had recognised that this needed to be improved and we saw that a robust system

Good



Summary of findings

had been put into place to ensure that all patients received an annual review. The GP lead attended an annual meeting with the community learning disability team to review patients' health needs and agree management plans.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. We saw the practice provided vulnerable patients with information about how to access various support groups and voluntary organisations.

We saw evidence that the practice had worked to the Gold Standards Framework for those patients with end of life care needs. Co-ordinated care for patients at the end of their lives ensured that 78% died in their preferred place of care.

Staff knew how to recognise signs of abuse or neglect 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.

Practice staff were intuitive to the needs of this group of patients and demonstrated that they had a personalised approach to helping them. Phlebotomy appointments were available at the practice.

People experiencing poor mental health (including people with dementia)

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 patients experiencing poor mental health, including those with dementia.

Staff told us that 91% of patients with dementia had received advance care planning and appropriate reviews. These patients had a named GP and continuity of care was prioritised for them.

Same day appointments and telephone triage with a GP was offered to ensure that any health needs were quickly assessed for this group of patients.

The practice told patients experiencing poor mental health how to access various support groups and voluntary organisations. Staff had knowledge on how to care for patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing above the local and national averages in all but one indicator. A total of 245 survey forms were distributed and 124 were returned. This represented a 50.6% return rate of the surveys sent out.

- 90% of patients found it easy to get through to this practice by phone compared with the CCG average of 81% and the national average of 73%.
- 97% of patients were able to get an appointment to see or speak to someone the last time they tried compared with the CCG average of 92% and the national average of 85%.
- 95% of patients described the overall experience of this GP practice as good compared with the CCG average of 88% and the national average of 85%.

- 93% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 85% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 46 comment cards which were all positive about the standard of care received.

We spoke with four patients and with two members of the Patient Participation Group (PPG) during the inspection. All patients said they were satisfied with the care they received and thought staff were approachable, committed, and caring.

East Bridgford Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to East Bridgford Medical Centre

East Bridgford Medical Centre provides a range of services to 6755 patients living in an area that covers 20 villages with furthest points of Elston, Lowdham, Radcliffe on Trent, Bingham and Whatton.

The practice is in the Rushcliffe Clinical Commissioning Group (CCG) area. The practice serves an area where income deprivation affecting children and older people is significantly lower than the England average. Additionally, the area has a lower than average number of patients living with a long standing health condition and with health related problems affecting their daily life. The practice also has significantly fewer patients claiming disability allowance. The practice has a comparable average for patients in paid work or full time education and a significantly lower number of patient's unemployed than the England average.

The practice holds a GMS contract, has a dispensary, and is a training practice with one GP trainer. A training practice has trainee GPs working in the practice; a trainee GP is a qualified doctor who is undertaking further training to become a GP. A trainer is a GP who is qualified to teach, support, and assess trainee GPs. There are currently three trainee GPs working in the practice. The practice offers a

range of services including sexual health, long term conditions, and travel advice. In addition the practice holds a contract to offer anti coagulation services. An anticoagulant is a medicine that stops blood from clotting.

The practice has a dispensary and we included this in our inspection.

The practice team consists of three GP partners, two male and one female, one salaried GP and two GP registrars, three female nurses, and two health care assistants. The non-clinical team consists of one practice manager, five reception staff, and three administrative staff. The practice employs eight dispensary staff.

The practice is open between 8am and 6.30pm Monday to Friday. Late surgeries are offered on some Mondays, Tuesdays, or Thursdays with appointments from 6.30 to 7.30pm.

Nottingham Emergency Medical Services provide out of hours cover when the practice is closed.

We previously inspected this practice on 25 August 2015. We found that the practice required improvement.

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.

The inspection was carried out to check that improvements had been made to meet legal requirements in respect of compliance with regulations 12 and 18 of the Health and Social Care Act (Regulated activities) Regulation 2014, following our comprehensive inspection on 25 August 2015.

Detailed findings

When we inspected the practice on 25 August 2015 we were concerned about;

- the safe care and treatment of patients in respect of ensuring the proper and safe management of medicines.
- doing all that is reasonably practicable to mitigate any risks.
- ensuring that staff received such appropriate support, training, professional development, supervision, and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

How we carried out this inspection

For example:

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 were provided for specific groups of people and what good care looked 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 our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 6 May 2016. During our inspection we spoke with a range of staff including three GPs, nursing, reception and administration team staff. We spoke with the manager of a care home, four patients who used the service and two members of the patient participation group. We observed how patients were being cared for and reviewed four comment cards where patients shared their views and experiences of the service.

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.

Are services safe?

Our findings

The practice was rated as inadequate for providing safe services in our previous report of 25 August 2015. The issues which led to this rating had been addressed during this inspection.

Safe track record and learning

The practice used a wide range of information to identify risks and improve patient safety. For example, reported incidents, 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.

The practice had specifically designed forms, available electronically or in paper form available to staff to report incidents and near misses. These were reported to the practice manager or GP partners.

Significant events were discussed at monthly meetings. Learning was shared and cascaded to the staff by the managers and at staff meetings.

We reviewed safety records, incident reports, and minutes of meetings where these were discussed over the past 12 months. The practice had introduced and embedded systems to manage these consistently. There had been 23 events recorded in the past 12 months. We reviewed a sample of them and found that they were well documented; evidence of actions and shared learning was noted. For example, whilst following up a verbal complaint the practice manager noticed that although the patient's notes reflected the relevant information from an annual review, the next date for recall had not been set. This could have resulted in the patient not being called for their next annual review at the appropriate time. This was immediately rectified, the staff member made aware and a reminder was given to all staff to set the recall date.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements reflected relevant legislation and local requirements. Practice policies were accessible to all

staff on the intranet and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Posters were displayed in the consulting rooms giving the contact details.

There was a lead GP for safeguarding and multi-disciplinary team meetings were held each month, minutes were available for staff. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Practice staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurse practitioners were trained to child protection or child safeguarding level three.

Vulnerable patients were highlighted on the practice electronic system. This included children subject to child protection plans and patients with a diagnosis of dementia.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and it was practice policy to ensure that all staff, irrespective of role, received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training including hand washing.

A comprehensive infection control audit was undertaken in January 2016, improvements were identified, and actions were noted. For example, the waiting room chairs were upholstered, (infection prevention is harder to maintain with upholstered chairs rather than those that can be wiped easily), they were cleaned regularly however; the action log reflected that partners would review this.

A sharps injury policy was in place and staff were aware of the actions to take. All clinical waste was well managed.

The practice held records of staff immunisation status.

Are services safe?

- The practice had a robust system to manage safety alerts. The practice manager received safety alerts such as those from Medicines and Healthcare products Regulatory Agency (MHRA). These were cascaded to appropriate staff including the dispensary. For example, a safety alert was received in February 2016 regarding patients taking a medicine who could be at risk of abnormal pregnancy outcomes. To identify any patients that could have been affected the practice completed a search and reviewed their medical records. The patients identified were appropriately managed.

We visited the practice dispensary and reviewed medicines that were stored and available for use within the practice treatment rooms. There was a lead GP and a dispensary manager had been appointed since our last inspection. The practice delivered medicines to patients who were unable to attend the practice. All members of staff involved in dispensing medicines had received appropriate training.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security, and disposal).

Processes were in place for handling repeat prescriptions for patients who were taking high risk medicines. The practice performed monthly searches for patients on medicines such as methotrexate, and contacted them for a blood test if needed.

Medicines were stored safely and records of fridge temperatures were reviewed appropriately.

Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). These were well presented and had been reviewed in December 2015 and January 2016. In addition the practice had introduced a dispensary daily jobs list, these check lists were detailed and ensured that staff signed to confirm that tasks had been completed. Tasks included checking for safety alerts and handing over keys to the controlled drug cupboard. They had also introduced a comments book for effective and safe hand over between staff.

Stock levels and expiry dates were checked monthly. All medicines we checked were within their expiry date. The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their

potential misuse) and had procedures in place to manage them safely. Controlled medicines were stored correctly and the dispensary staff demonstrated a consistent approach towards the storage, recording, and destruction of controlled medicines.

Significant events or near misses were well managed. Any reported incident was sent to the dispensary manager to be logged and was discussed at the monthly dispensary meeting. Staff we spoke with told us that they found this valuable and that the meetings were open and there was a no blame culture. For example, the dispensary manager noticed that the number of reported incidence was falling, through discussion with the staff, it was identified that the form they used was long and detailed, and due to time constraints staff were not always completing this. A new simpler form that could be used to record and report the incident was designed. For events that required further investigation, time was allocated for a more detailed form to be completed. Staff told us that this enabled them to report incidences however minor.

Regular medicines audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines.

There was a repeat prescription policy for dispensary staff to follow. Uncollected prescriptions were highlighted to the GPs to ensure patient safety. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patients collecting controlled drugs were asked for identification and to sign for collection.

- A nurse practitioner had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. A GP provided mentorship and all GPs gave support for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw that these were signed and dated. The practice confirmed that the health care assistant worked under a person specific direction when giving injections.
- A robust recruitment process was in place, we reviewed three personnel files, these were well presented, and appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration

Are services safe?

with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. All staff had received a Disclosure and Barring Service (DBS) check.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There was a health and safety policy available with a poster in the office. The practice reviewed its policy for health and safety in April 2016.

The practice used risk assessments to monitor the safety of the premises. For example, for the control of substances hazardous to health and infection control. Testing for legionella (a bacterium that can grow in contaminated water and can be potentially fatal) had been undertaken. Other risk assessments included the safe management of waiting areas. The practice had more than one waiting areas that were not in sight of the reception area. Staff were aware of the need for patients that were vulnerable or particularly unwell to be asked to wait in the area where the receptionist could observe them and seek medical assistance urgently, if needed.

A full fire risk assessment had been carried out on 26 April 2016 with no remedial actions to be taken. Fire extinguishers had been checked 15 March 2016 and two staff members acted as fire wardens. Regular test of fire alarms and frill drills had been carried out.

All electrical equipment had been checked in August 2015 to ensure that it was fit for purpose. Clinical equipment had been calibrated on 14 July 2015 to ensure it was working properly.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. In addition the clinical rooms had push button alarms.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies of this were held in the GP partner's homes.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and locally produced quality standards. The practice held a weekly clinical meeting where guidelines were reviewed and best practice shared. The GPs met regularly with GPs from other local practices and locums working in the area giving the opportunity to share learning with their peers.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96.3% of the total number of points available with 9.9% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from QOF 2014 0215 showed:

- Performance for diabetes related indicators was 93.2%
The practice rate of exception reporting was comparable to the CCG and national rates.
- The percentage of patients with hypertension (high blood pressure) having regular blood pressure tests was 100% which was in line with the CCG and national averages. Exception reporting for this indicator was comparable to the CCG and national rates.
- Performance for mental health related indicators was 94% which was 4.1% below the CCG average and 1.2% above the national average. The exception reporting percentage for this indicator was 7.3%; this was lower than the CCG average of 10.1% and the national average of 11.1%.

There was evidence of quality improvement including clinical audit.

There had been 16 clinical audits undertaken in the last two years, we reviewed two of these where the improvements made were implemented and monitored.

For example, an audit was undertaken and looked documentation of minor operations and outcomes. This audit had cycles undertaken in 2013, 2014 and 2016. Improvements had been recognised for example,

- Evidence of documented written consent in the patient's records, in 2013 was 26% and in 2014 it was 54% and in 2016 it was 100%.
- There were no reported incidences post-operative wound infections; this has remained at 100% through each cycle.

Data from the CCG showed that the practice was consistently performing well compared with other local practices. We noted that in previous years, the practice had been identified as having a higher rate than other local practices of patients attending the local accident and emergency (A&E) department, during the hours when the practice was open; this had been recognised as incorrect. The practice had systems to review patients who did attend A&E and recent data had shown the practice had the lowest number of patients attending A&E.

Effective staffing

Staff had the skills, knowledge, and experience to deliver effective care and treatment.

- The practice had a robust induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Personalised induction plans were produced with regular reviews. The dispensary team had introduced a competency assessment document. This included a written aim of the task, links to the appropriate standard operating procedure and evaluation points. We reviewed this document and found that it was detailed and clear to understand.
- The learning needs of staff were identified through a system of appraisals, meetings, and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. All staff had received an appraisal within the last 12 months. Staff we spoke with told us that they had protected time for training and requests

Are services effective?

(for example, treatment is effective)

for additional training were usually granted. Staff received training that included safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

- The practice nurses held a monthly meeting where they would discuss such topics as revalidation, clinical updates and share their learning. For example, minutes from the meeting held on 10 October 2015 discussed the need for additional health care assistant hours to ensure that the nursing team had capacity to meet patient demand. The partners agreed this.

Coordinating patient care and information sharing

- Referrals for patients to secondary care or other agencies were well managed. All routine referrals were completed within five days and most went through the referral centre through the choose and book system (C&B). C&B is an electronic system between primary and secondary care and does not require any paper copies to be sent. This system increased the speed of referral receipt and reduced the risk of delay or confidentiality breaches. Referrals for urgent care such as a two week wait pathway were completed within 24 hours and patients were followed up to ensure that they had received an appointment.
- The practice staff worked with other services to meet patients' needs and manage those patients with more complex needs. This included community nursing teams and health visitors. The practice worked to the Gold Standards Framework when co-ordinating end of life care for patients. Regular meetings with the wider health team were held to manage and plan patients care. A report from Nottingham Citycare EPaCCS data report showed that 78% of patients who had been referred to the service died in their preferred place of care.
- Patient notes were completed by the practice on an electronic system and this ensured that emergency services staff had up to date information of vulnerable patients.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, scanned

copies of letters and test results from hospitals. All communication was sent to the GPs, who took any required actions. We reviewed this system and found this to be well managed to ensure that patients were safe.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young patients, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

All staff were aware of Gillick competency and applied it in practice. Practice staff we spoke with told us that they were aware that the medical records of young people often held the mobile number of their parents or guardians. The practice staff would always check the mobile telephone number of young people and confirm if they wished to receive a text confirming their appointment.

Supporting patients to live healthier lives

The practice's uptake for the cervical screening programme was 89.5% which was above the CCG average of 88% and the national average of 81.8%.

A policy to offer telephone reminders for patients who did not attend for their cervical screening test was in place. The practice nurses undertook an audit in July 2015 to monitor the number of inadequate samples that had been rejected. The nurses recognised that their results were comparable to other local practices.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- The number of women screen for breast cancer was 81.9% this was in line with the CCG average of 81.5% and higher than the national average of 72.2%.

Are services effective?

(for example, treatment is effective)

- The number of patients screened for bowel cancer was 68.8% this was similar with the CCG average of 67.9% and higher than the national average of 58.3%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example,

- Immunisation rates for under two year olds ranged from 96.2% to 98.2% compared to with CCG range 96.6% to 97.7%
- Immunisation rates for five year olds ranged from 95.5% to 98.5% compared to with CCG range 94.2% to 98.6%

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. In the previous 12 months the practice had offered 757 patients a health check, 64% had attended and received advice on topic such as healthy lifestyle and exercise.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed staff being polite and helpful to patients.

All the comments we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

We also spoke with two members of the patient participation group. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. In particular they highlighted that the practice listened to them and that they felt valued by the management team. A manager of a local nursing home told us that the patients living in the home were happy with the service that the practice provided. The manager reported that a regular GP attended the home weekly, and during the ward round would speak with patients and their relatives. The manager reported the GP had displayed kindness and respect to patients, relatives, and staff.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity, and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 99% of patients said the GP was good at listening to them compared to the clinical commissioning group CCG average of 90% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 95% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.

- 93% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above the local and national averages. For example:

- 93% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Information leaflets were available in easy read format.
- There were various display boards in the waiting room including information about cancer for men, women, and children.

Patient and carer support to cope emotionally with care and treatment

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 95 patients as carers (1.5% of the practice list). The practice identified carers at registration and by posters and information in the practice. The practice hosted two members of the Carers

Are services caring?

Federation in the practice. A practice staff member, who was the carers champion for the practice worked closely with the team to encourage carers to have an appointment. The carers champion had made 28 referrals to the Carers Federation and this had resulted in those patients receiving both financial and practical support. The practice had identified that they had five young carers. Staff told us that if any carer needed flexibility for appointments, this was arranged for them.

Staff told us that if families had experienced 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff at the practice worked hard to understand the needs of their patients. Both clinical and non-clinical staff demonstrated a clear understanding of the concept of personalised care for the patients according to their individual needs. The practice was flexible with their appointments, for example the women's health lead would see patients who required contraception at times convenient to them. The school nurse had the GPs mobile number and could contact the GP at any time to seek advice or arrange appointments for young patients.

The practice was proactive in engaging with other services and providing facilities for them to enable patients to be seen at the practice, closer to their homes for additional services.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- There were longer appointments or home visits available for patients with a learning disability or dementia.
- Home visits were also available for older patients and others that needed one. The practice had a system in place to assess if a home visit was clinically necessary and the urgency of the need for medical attention.
- Facilities for patients with disabilities were available. There were automatic doors and mother and baby facilities in place. There was a hearing loop available for patients who wore hearing aids.
- The practice offered smoking cessation advice and weight management advice.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11am every morning; this was extended if there was a higher demand for appointments or staff shortages due to sickness. Afternoon appointments were available from 3.30 or 4pm

to 6.30pm daily. The practice offered extended hours for pre booked appointments on Monday, Wednesday, and Thursday evening to 7.30pm. In addition to pre-bookable appointments which could be booked up to four weeks in advance, urgent appointments were available for people who needed them. Appointments were available on line; this was advertised in the waiting areas and the practice booklet. Continuity of care was a priority for the practice, the practice did not use locum GPs regularly, instead the GPs at the practice covered for each other in the event of leave.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 75%.
- 90% of patients said they could get through easily to the practice by phone compared to the CCG average of 81% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had improved the system in place for handling complaints and concerns and collated both written and verbal complaints. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for dealing with these.

We saw that information was available to help patients understand the complaints system. There were leaflets and posters displayed in the waiting area and information was available on the web site. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

There had been five written complaints and thirteen verbal complaints or feedback recorded in the past 12 months. We looked at two complaints and found these had been dealt with appropriately.

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

Staff described a consistent vision and ethos to offer good care and treatment to their patients, and were determined to meet their own mission statement, values, and principals. The practice management team were proactive in key areas such as meeting the demands of the future and looking at best use of skill mix.

The practice staff were aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty.

The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording, and managing risks, issues, and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners and management team in the practice demonstrated they had the experience, capacity, and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners and managers were approachable and always took the time to listen to all members of staff.

There was a clear leadership structure in place and staff felt supported by management.

- We saw from the various minutes that the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued, and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The GPs participated in roles outside of the practice for example one GP was an education lead for the local area and GPs from the practice were cabinet members of the local CCG. This enabled them to meet with other local practices and ensured that they were able to share learning and updates from their peers.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public, and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG told us that the practice had funded 1000 patient surveys to be delivered to patients home. Patients were selected at random from different age groups. This would ensure that they received feedback that would reflect a wider range of patient's views. We saw that the PPG had placed collection points in the community, including in a local hotel.

Are services well-led?

Good 

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

- The practice had gathered feedback from staff through meetings, and one to ones. Practice staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

- There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.
- In July 2015, the practice, in joint working with the CCG employed a fracture liaison nurse who delivers intra venous medicines to patients in the community. This avoiding the patient attending hospital and brings care close to the patients home. This services had recently won a nursing award and had been recognised by the British Medical Association (BMA).The practice have been successful in securing funding to not only continue with the service but to engage another nurse. This service is provided from East Bridgford Medical Centre and is available to all practice in the Rushcliffe CCG.