Churchfields Medical Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Churchfields Medical Practice on 26 November 2014. Overall the practice is rated as providing a good service across all six key questions and in relation to all population groups.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Most patients we spoke with found it easy to obtain a convenient appointment with the GP/nurse; with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available and easy to understand.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Importance was given to ensuring that carers were provided with adequate support in relation to their own health needs and caring role.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed on most occasions.
- There was a clear leadership structure and a commitment to improving the quality of care and services for patients. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should

Summary of findings

- Ensure a risk assessment is undertaken in relation to GPs not always carrying emergency medicines when making home visits
- Ensure recruitment arrangements include all necessary employment checks for all staff. The policy should reflect the pre-employment checks required by law.

Ensure health and safety information is actively sought from the premises manager to assure the practice that suitable checks are being undertaken.

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, reviewed and addressed. Risks to patients were assessed and well managed overall.

Some of the systems to help keep patients safe needed strengthening to ensure they were robust and were being addressed by the practice. This included medicines management, recruitment and health and safety checks.

There were enough staff to keep patients safe. Suitable arrangements were in place to review the suitability of equipment and to deal with emergencies and major incidents within the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

The Quality Outcomes Framework (QOF) and benchmarking data showed most patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it in the assessment of patient's needs.

Patients' needs were assessed and care was planned and delivered in line with evidence based practice and current legislation. This included assessing patient capacity and promoting good health. Patients were regularly reviewed to assess the effectiveness of their care and treatment, and clinical audits were used to monitor and improve patient outcomes.

Staff worked in partnership with other health and social care services to meet patients' needs. Effective systems were in place to ensure appropriate information sharing and the management of the service. Health promotion information was available to patients and carers, including a range of screening services. The practice had identified areas of improvement in relation to health promotion including increased uptake of immunisation rates.

Summary of findings

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

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients described the staff as polite, helpful and caring. Most patients said they were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment. This view was supported by data from the 2014 national GP patient survey. The data showed patients rated the practice higher than other local practices for some aspects of care including involvement in decision about their care.

Staff supported patients to cope emotionally with their health and medical needs. Information to help patients understand the available services was accessible within the practice. Importance was given to ensuring that carers were provided with adequate support in relation to their own health needs and caring role.

People were supported to self-manage their conditions and to maintain their independence where possible. We saw that staff treated patients with kindness and respect, and maintained their privacy, dignity and confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice 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. Suitable arrangements were in place to monitor priority areas such as reducing attendance to accident and emergency (A&E). Patients received appropriate support following hospital discharge and this included a review of their care plan.

Most patients said they found it easy to make an appointment, with urgent appointments available the same day. A few patients felt improvements were still required to the practice's phone system and the availability of non-routine appointments with the GPs.

Comprehensive information on the opening hours and appointments was available to patients on the practice website, newsletter and in the practice. The practice operated a nurse led triage system which supported the practice in providing responsive care for routine and urgent appointments.

Summary of findings

Home visits and longer appointments were available for patients who needed them such as older people, patients with learning disabilities, those experiencing poor mental health or with complex needs. Robust systems were in place to monitor the practice's phone access and the appointment system; in liaison with patients, staff and other stakeholders.

The practice had good facilities and was well equipped to treat patients and meet their needs. Reasonable adjustments were in place to ensure equal access for patients with disabilities, impairments and patients whose first language was not English. Information about how to complain was available and easy to understand. Records reviewed showed the practice responded quickly to issues raised and there was shared learning from complaints amongst the staff.

Are services well-led?

Good

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

The practice had a clear vision and strategy in place and staff were clear about their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Staff told us there was a focus on patient safety, service improvement and achieving best practice. The practice culture encouraged openness and management were aware of the practice strengths and areas of development.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. Effective governance frameworks were in place and processes of accountability were clearly set out and understood. There were robust systems in place to monitor the practice performance and improve the quality of care provided.

The practice proactively sought feedback from staff, patients and the patient reference group (PRG); and acted on this. Most staff had received inductions, regular performance reviews and attended staff meetings and events. The practice was involved in the training of foundation year two doctors. The foundation programme is a two-year generic training programme which forms the bridge between medical school and general practice training.

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.

Patients aged over 75 had a named GP and received a health check to monitor their wellbeing. The practice engaged carers to ensure their needs and the needs of the older person were being met. Information on healthy living and self-care was available on the practice website and leaflets in the surgery.

The practice offered proactive, personalised care to meet the needs of the older people in its population. This included a range of enhanced services, for example, in dementia and hospital admission avoidance. Follow-up consultations took place with older people following hospital discharge and their care plans were updated to reflect their current care needs.

District nurses, community matron and palliative care nurses were involved in practice meetings, to ensure the co-ordinated care for older patients with complex health needs or receiving end of life care.

The practice was responsive to the needs of older people by offering home visits, nursing home visits, flu clinics and rapid access appointments for those with enhanced needs. The practice had a good working relationship with local care homes. Staff were able to recognise signs of abuse in older patients and knew how to escalate any safeguarding concerns.

People with long term conditions

Good

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

The practice maintained a register of patients with chronic diseases and was proactive in undertaking health reviews as part of monitoring their health needs. Patients with long term conditions were offered an annual review to check that their health and medication needs were being met.

Nursing staff had lead roles in chronic disease management and led clinics for asthma, diabetes and ischaemic heart disease for example. Longer appointments and home visits were available when needed.

Summary of findings

Patients at risk of hospital admission were identified as a priority and any unplanned admissions and discharges were monitored. Follow up consultations took place following hospital discharge and care plans were updated to reflect any additional needs.

For patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. They included the community matron, end of life care team and district nurses.

Patients were referred to other services to support them to live healthier lives. This included Nottingham Circle for social activities or practical help in the home. Further information is available on the practice website with many links to advice and organisations offering support. The practice also offered use of assistive technology such as text reminders for taking medicines.

Families, children and young people

Good

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

The practice had effective emergency processes in place to ensure children and young people received appropriate treatment and referrals in the event of an emergency. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice had good working arrangements with the midwives and health visitors; and three monthly meetings were held to review patient care needs. An external health professional we spoke with told us the practice was responsive and effective in ensuring the co-ordinated care of children with complex needs or when concerns were raised.

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.

All staff had received child safeguarding training appropriate to their role. Children and young people were treated appropriately and their consent to treatment obtained in accordance with current legal guidance.

Women had access to ante-natal and post natal clinics; and staff described the practice as breastfeeding friendly. Childhood immunisation clinics and mother and baby clinics were available.

Summary of findings

The practice was working towards improving immunisation rates for all standard childhood immunisations due to low uptake by some of the community groups. Family planning and emergency contraception were also offered as a service.

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).

We found the care needs of this population group had been identified and services offered had been adjusted to ensure they were accessible, flexible and offered continuity of care. This included online services to book appointments and order prescriptions outside school and / or working hours. The practice offered emergency appointments, telephone consultations where appropriate, and a text message reminder for appointments and test results.

Extended opening hours were available every other Saturday and early morning for appointments with the GP, practice nurse and / or health care assistant. Effective recall systems were in place to ensure patients attended their health checks, and a range of health promotion services were provided. This included blood pressure checks, cervical screening and contraceptive services.

Reading material on minor illnesses was also accessible within the practice and on the website. Non registered patients were able to access some services such as for phlebotomy and electrocardiogram (ECG) monitoring following an appropriate referral under the Any Qualified Provider (AQP) services. An ECG records the electrical activity of the heart.

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. Annual health checks for patients with learning disabilities were undertaken and longer appointment times were offered for those that needed them.

The staff worked closely with families and carers of vulnerable patients to improve their care and treatment. This included sign posting patients to various support groups and voluntary organisations; as well as providing supporting letters for housing and benefits.

Summary of findings

Patients needing support with alcohol dependency could access Last Orders onsite. Last Orders delivers a range of services related to alcohol dependency and practical advice to adults in Nottingham City and Nottinghamshire.

The practice worked closely with multi-disciplinary teams in the case management of vulnerable people. Systems were in place to identify and follow-up patients at risk of abuse. This included sharing information about people at risk of abuse with relevant agencies where appropriate. Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children.

Interpreting facilities were available for patients whose first language was not English and deaf people could access type talk or British Sign Language. Type talk is the national telephone relay service which enables people who are deaf or with speech or hearing difficulties to communicate with hearing people using the telephone network. Travellers from a local site were able to register with the practice as registration arrangements were flexible.

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 maintained a register of patients with mental health needs to monitor their wellbeing and inform service provision. Patients were offered an annual review of their physical and mental health needs including medicines, tobacco and alcohol consumption. Onsite counselling services were available and patients could also access a variety of treatments including talking therapies, books on prescription and health promotion advice.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. These included the crisis team, community psychiatric nurse, community matron and the dementia outreach team.

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

Information on how to access various support groups and voluntary organisations including MIND (a national mental health charity that provides information and support) was available to patients.

People at risk of dementia were identified and offered an assessment to detect for possible signs of dementia. Where dementia was suspected, a referral for diagnosis was made. Staff

Summary of findings

had received training on how to care for people with mental health needs and dementia. This included providing care in line with a patient's wishes and the Mental Capacity Act 2005. Advance care planning for patients with dementia was also provided where appropriate.

Summary of findings

What people who use the service say

We spoke with eleven patients including seven members of the Patient Reference Group (PRG). The PRG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. Members of the PRG told us the practice was well-led and they worked well with the practice to improve the service. We received comment cards from seven patients and spoke with a health visitor and their manager.

Most of the patients we spoke with expressed a high level of satisfaction about the way care and treatment was delivered; and they felt that the services had improved over the years. Patients told us they were involved in decisions about their care and treatment, and clinicians provided adequate information to inform their decision making. They also said they felt listened to and were able to raise concerns with staff if they were unhappy with the care received.

Some patients gave specific examples where they had been referred by the GPs to other health services for further medical tests, and test results being shared promptly with them. Patients reported their health needs and medicines were reviewed regularly. Patients described the staff as friendly and caring, and felt they treated them with dignity and respect. Patients told us the premises were clean, and that the facilities were accessible and appropriate for their needs.

Most patients reported a positive experience of accessing urgent appointments as a result of the triage system used by the practice. A few patients felt improvements were still required as they did not find it easy to get through to the practice by phone or access suitable appointments at times. Specific areas related to the GP appointments only being bookable a week in advance, and appointments with the female GPs being subject to a two or three week wait.

We saw records to confirm that the practice regularly reviewed these areas of concern, and had made changes to the telephone and the appointment system to improve access for patients. Appointment bookings and continuity of care had been focus areas for the practice's 2013 patient survey. The PRG had agreed the action points from the survey to improve the service and these are available on the practice website.

We looked at the 2014 national GP survey, which 115 patients completed. The findings were compared to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

Areas where the practice scored highest and above other practices within the local CCG included: getting through to the practice by phone, access to a convenient appointment and satisfaction with the surgery's opening hours. Areas for improvement included: waiting times to be seen by the GP and / or nurse and being able to get to see or speak to a preferred GP.

Areas for improvement

Action the service SHOULD take to improve

- Ensure a risk assessment is undertaken in relation to GPs not always carrying emergency medicines when making home visits
- Ensure recruitment arrangements include all necessary employment checks for all staff. The policy should reflect the pre-employment checks required by law.
- Ensure health and safety information is actively sought from the premises manager to assure the practice that suitable checks are being undertaken.

Churchfields Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Churchfields Medical Practice

Churchfields medical practice provides primary medical services to approximately 10,060 patients from a single location in the Old Basford area of Nottingham.

The practice is registered with the Care Quality Commission to provide services at the following address: Old Basford Health Centre, 1 Bailey Street, Old Basford, Nottingham, NG6 0HD. The practice offers a range of services including minor surgery, family planning, maternity care, phlebotomy (blood testing), vaccinations and various clinics for patients with long term conditions.

The practice holds the following contracts with the NHS: General Medical Services (GMS) to deliver essential primary care services and Personal Medical Services (PMS) to provide personal medical services. The practice opted out of providing the out-of-hours service to their own patients.

The practice employs 17.99 whole time equivalent staff, including administrative and nursing staff. The nursing team include: a nurse manager, two nurse practitioners, two practice nurses, two healthcare assistants and a phlebotomist. The non-clinical staff includes a practice manager, deputy practice manager, reception supervisor, eight reception administrators, an officer supervisor and four staff undertaking secretarial and administrative tasks.

The practice partnership comprises of four GPs with equal numbers of male and female staff. Two female salaried GPs are also employed. The practice is a training practice for foundation year two doctors and two students were on placement when we inspected. The foundation programme is a two-year generic training programme which forms the bridge between medical school and general practice training.

Why we carried out this inspection

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

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

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?

Detailed findings

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 November 2014. During our visit we spoke with a range of staff (GPs, nurse manager, practice nurses, practice manager, health care assistant, administration and secretarial staff).

We spoke with eleven patients who used the service including seven members of the practice's Patient Reference Group. The PRG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We observed how people were being cared for, checked the premises and the practice records. We received four comment cards where patients shared their views and experiences of the service. We also spoke with two health professionals attached to the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. A system was in place to ensure that staff were aware of national patient safety alerts and where action needed to be taken.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. We found risks to patients were assessed and appropriately managed on most occasions. Patients told us they felt safe when using the service and reported no safety concerns.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. This included: significant events being a standing item on the practice meeting agenda and a process being in place to review actions from past significant events and complaints.

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. They told us the practice was open and transparent when things went wrong.

We reviewed nine records of significant events that had occurred during the last 12 months. These were completed in a comprehensive and timely way, including the learning. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

There was evidence that the practice had learned from these events and that the findings were shared with relevant staff. For example, all administrative staff were required to repeat information governance training following a significant event related to patient records.

We found further learning was required for one significant event related to medicines management, including carrying out of the significant event analysis in liaison with other agencies that were involved. This was discussed in detail with the practice management and we were assured this would be reviewed following our inspection.

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 staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training.

Staff 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 documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding children and vulnerable adults. They could demonstrate they had been trained to an appropriate level to enable them to fulfil this role. Records reviewed demonstrated good liaison with other partner agencies such as social services, health visitors and the hospital. All staff we spoke with were aware who the GP lead was and who to speak with in the practice if they had a safeguarding concern.

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 GPs told us they used 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. Other at risk patients included children and young people with a high number of A&E attendances, and children who persistently failed to attend appointments for childhood immunisations.

There was a chaperone policy in place but this did not sufficiently detail the role of staff. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or

procedure. However, staff we spoke had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The chaperone policy 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. Reception staff would act as a chaperone if nursing staff were not available and appropriate DBS checks had been undertaken.

Medicines management

All but one patient we spoke with told us the system in place for obtaining repeat prescriptions worked well and enabled them to obtain further supplies of medicines within 48 hours. Patients could collect their repeat prescriptions from the medical centre or directly at the local chemist. Local pharmacies also delivered medicines to housebound patients.

A system was in place for reviewing repeat medicines for patients with multiple health needs and medicines. 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. Manual prescriptions pads were secured in a locked cabinet and had serial numbers for audit trail.

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

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

We saw records of practice meetings and clinical audits that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic drugs for prescribing within the practice.

National data showed the practice's performance for hypnotics and antibiotic prescribing was comparable to the national average. This included medicines used to treat pain such as ibuprofen, naproxen and nonsteroidal anti-inflammatory drugs (NSAIDS).

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. However, recent significant events related to the controlled drug Zomorph (opioid painkiller) showed systems in place needed strengthening and we assured by the GPs that systems were in place to address this.

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.

Cleanliness and infection control

We observed the premises to be visibly 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 who had undertaken further training to enable them to provide advice and training on the practice infection control policy. The lead person was the nurse manager. Most staff had received induction training about infection control specific to their role and refresher / annual updates.

An infection control policy and supporting procedures were available for staff to refer to. This 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. A hand hygiene audit had also been undertaken in June 2013 and plans were in place to carry out regular audits.

Good

Are services safe?

We saw records that confirmed the practice was carrying out regular checks to reduce the risk of Legionella (a bacterium that can grow in contaminated water and can be potentially fatal) to patients, staff and visitors. This included monthly monitoring of water temperatures and flushing of water taps. Legionella water samples had been taken on 22 July 2014 and regular checks were in line with the risk assessment report.

An external agency had recently completed an infection control audit and the practice had received the results on the day of our inspection. The practice was in the process of completing improvements identified and the nurse manager assured us they would be monitoring the action plan to ensure it was implemented. Previous infection control audits had been carried out and remedial actions addressed. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment in July 2014; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

We reviewed three staff files and found they contained most of the evidence to demonstrate 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. However, this did not include all the information required by law before staff started working at the practice. We noted that records relating to staff induction were not always kept and the manager told us this would be improved on for future new staff.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. This took account of factors such as: patient demand for services; audits of the appointment system; clinics and services offered; the skills, experience and availability of staff.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were enough staff on duty to keep patients safe. The management acknowledged that the practice had been subject to some staff turnover in recent years and had difficulties in recruiting GPs.

However, succession plans were in place to recruit additional staff and to maintain the partnership and GP skill mix. For example, the practice had recently recruited an additional nurse, and the health care assistant had been provided with additional training to provide more screening services. Minutes of meetings reviewed showed staffing arrangements were regularly discussed at the practice meetings.

Monitoring safety and 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. However, these needed strengthening as the checks undertaken by the premise manager (landlord) were not always sought/shared with the practice, to assure them that all satisfactory checks had been completed.

Records reviewed showed checks of the building and the environment were undertaken. A health and safety risk assessment had been completed on 31 October 2014 by an external company.

The practice had recently received the report and were looking to address areas for improvement noted. This included: ensuring that all accident reports were investigated and followed up, and that health and safety was discussed on the meeting agenda.

Good

Are services safe?

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Emergency lighting testing was undertaken monthly.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

- There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.
- There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made (for example childhood sepsis).
- Emergency processes were in place for acute pregnancy complications.
- Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.
- The practice monitored repeat prescribing for people receiving medication for mental ill-health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support and cardio pulmonary resuscitation (CPR). 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).

When we asked members of staff, they all 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 concerning a patient and 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. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

GPs need to carry a range of drugs for use in acute situations when on home visits. However, all three GPs we spoke with reported they did not always carry any medicines in the doctor's bag when visiting the patients at home.

Most of the GPs were able to provide a rationale for this, as they were located only a short distance from the accident and emergency services of the hospital and had appropriate CPR training to deal with emergencies. These factors reduced the need carry emergency medicines. However they could not when requested demonstrate that a risk assessment had been undertaken to confirm this was safe and appropriate.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks associated with the service and staffing changes (both planned and unplanned) had been identified and mitigating actions put in place to manage this. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment in October 2013 and actions required to maintain fire safety were completed by March 2014. This included having appropriate signage in place, and ensuring that suitable fire extinguishers were available for use. A schedule of fire alarm testing was carried out at least weekly and staff were aware of the process.

A fire drill had been undertaken in July 2014 to ensure that staff were aware of evacuation procedures. The practice was also looking to increase the number of designated fire marshals to ensure staff were fully supported. Records showed that most staff were up to date with fire training and further training had been scheduled.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found patients received effective care through the assessment of their individual care needs, and their treatment was planned and delivered in line with current evidence-based guidelines. For example, three patients told us they had received satisfactory treatment following an assessment and diagnosis of specific long term conditions. They also felt their health needs were being met and was assured of their safety through the regular health checks undertaken.

Some of the patients also told us the GPs had arranged for them to have additional tests and scans at a local hospital to ensure they were appropriately diagnosed. Our discussions with the GPs and nurses showed staff completed thorough assessments of patients' physical and health needs, and these were reviewed when appropriate.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment and gave examples of how they implemented best practice guidance. For example, most staff accessed evidence-based guidelines from the National Institute for Health and Care Excellence (NICE), Nottingham area prescribing committee and the Nottingham City Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

One GP also showed us the practice guidelines they referred to when diagnosing, treating and managing specific medical conditions. For example, type two diabetes, hypertension, asthma and vitamin B12 deficiency. Some of these guidelines detailed how risks to patients should be assessed and monitored; as well as patient education offered to ensure patients were involved in the management of their care and treatment. Some guidelines were not dated, and did not include references to reflect the source of the evidence based guidance to ensure all clinicians were accessing up to date information from an appropriate professional body.

The GPs told us they lead in specialist clinical areas such as minor surgery, chronic disease management, research and medicines prescribing. There were supported by practice nurses who held regular clinics to monitor conditions such as diabetes, heart disease and asthma. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions. Our review of the clinical audits and meeting minutes confirmed this happened. Staff we spoke with were very open about asking for, and providing colleagues with advice and support.

We found GPs used national standards for the referral of urgent, two weeks and elective referrals. Records we looked at showed regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. The practice had a process in place to review patients recently discharged from hospital. This included patients being reviewed within 24 hours by their GP according to need.

The practice used computerised tools to identify and review patients with complex needs who had multidisciplinary care plans documented in their case notes. Interviews with GPs showed the culture in the practice was that patients were cared for and treated based on need, and the practice took account of patient's age, gender, race and culture as appropriate. Discrimination was avoided when making care and treatment decisions.

Management, monitoring and improving outcomes for people

We found the practice had robust systems in place to monitor people's health needs and patients were recalled for their annual health review based on their birthday month. This included patients with long term conditions, mental health needs and learning disabilities for example.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included scheduling clinical reviews, medicines management, participation in research and chronic disease management. The information staff collected was then collated by the management to support the practice to carry out clinical audits.

We looked at seven clinical audits that had been undertaken by the practice in the last three years. Most of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We found changes to treatment or care were made where needed to improve outcomes for patients.

For example, the practice had reviewed the care pathways for dermatology, ear, nose and throat (ENT), and trauma and orthopaedic referrals. The audit assessed whether the

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Are services effective?

(for example, treatment is effective)

referrals were appropriate and identified how the practice compared to other local practices in relation to referral rates. We found the audit identified learning points for the practice, which had been incorporated into working practice to improve patient outcomes.

These included: two of the GPs having training in minor surgery to enhance the dermatology skills within the practice; practice nurses were trained in the use of the HearChecker (a hearing screening device); and protocols were put in place to ensure that no referrals were processed unless the HearChecker test has been completed.

An audit aimed to reduce patient Accident and Emergency (A&E) attendance was also undertaken in relation to the following population groups: older people with co-morbidities, children with minor illnesses and frequent attenders. The outcome of the audit results were positive and the following systems were strengthened to ensure patients received effective care: fortnightly multi-disciplinary meetings with the care delivery coordinator, district nurse and community matron to review care planning arrangements; and the practice nurse-led triage service was initiated to deal with calls for urgent health care needs.

The practice was signed up to the enhanced service aimed at avoiding unplanned admissions. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We found effective systems were in place to ensure proactive and tailored care to reduce the risk of patients attending A&E.

The practice was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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 voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

For example, we saw audits in relation to the prescribing practice of medicines such as pregabalin used in the treatment of neuropathic pain, and seretide used in the management of asthma. The audits lead to prescribing guidelines being updated, although no significant changes were required in the GPs prescribing practice as it was appropriate.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The benchmarking data showed the practice had many outcomes that were comparable to other services in the area.

The CCG practice visit report for September 2014 showed the practice had made the following positive achievements: “excellent review of trauma and orthopaedics referrals”; ongoing management of patients with diabetes with improved QOF scores in relation to recording of blood pressure in patient notes (80.4% vs 71.8%); and good physical checks in those with enduring mental illness.

The report also identified areas of improvement including: health checks for patients with learning disabilities and reducing high emergency cancer rates. The 2013/14 QOF data showed the practice met all the minimum QOF standards in diabetes, asthma, chronic obstructive pulmonary disease (lung disease), dementia care, mental ill health and care of young mothers for example.

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 mandatory courses such as annual basic life support, health and safety and safeguarding vulnerable adults and children. We noted a good skill mix among the doctors; with services offered including joint injections, family planning and women’s health, children’s health and chronic disease management.

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

Good

Are services effective?

(for example, treatment is effective)

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).

Most staff had received an annual appraisal that identified learning needs from which action plans were documented, and plans were in place for the remaining staff to receive this. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

We found appraisals for nursing staff had not be undertaken regularly for the past two years and this had been attributed to staff changes due to maternity leave and sickness for example. However, appraisals for all nursing staff had been scheduled for December 2014 by the nurse manager.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, managing patients with minor illness and paediatric clinical skills in primary care. Those with extended roles for example seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs including those with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

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. The practice had a process in place to follow up patients discharged from hospital. We saw that the policy for actioning hospital communications was working well in this respect.

The practice held regular multidisciplinary team meetings to discuss the care and support needs of different population groups. For example, fortnightly meetings were held to discuss admission avoidance care, patients with complex health needs and vulnerable patients aged 75. Bi-monthly meetings were held to discuss vulnerable children and those on child protection plans.

Patients receiving end of life care were discussed as part of the gold standards framework (GSF) meetings every three months. The GSF helps health and social care professionals provide the highest possible standard of care for all patients who may be in the last years of life.

These meetings were attended by a range of health care professionals including GPs, district nurses, social workers, palliative care nurses, health visitors and the community matron. Agreed decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

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.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Staff told us that all out of hours information was processed before 8am to ensure this was available in patient notes before the start of clinics. For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

At the time of our inspection, the summary care record (SCR) was accessible to health care professionals in other services. The practice planned to make the SCR available to patients on-line in 2015 . A SCR provides faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

Electronic systems were also in place for making referrals, including choose and book system. Choose and book is a

Good

Are services effective?

(for example, treatment is effective)

national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported this system was easy to use.

A weekly report was produced to check that an appointment had been booked for all two week wait urgent referrals made for patients with suspected cancer and this was noted on the patient record. If patients did not attend their appointments this was flagged up with the named GP and followed-up.

The practice told us as part of quality improvement work they were looking to improve their information systems to deliver quality care. For example, the practice was piloting a fast track process of scanning information to patient records in an attempt to make this process more efficient. This had reduced the workload for the duty doctor from scanning approximately 90 letters a day to about 20 without impacting on the care of patients.

The practice was also working with the end of life team to implement the electronic palliative care co-ordination systems (EPaCCS) template to improve data capture and discussions for palliative patients during GSF meetings. We found staff were supported with a range of protocols to guide them in the processing of information including x-ray and pathology results.

Consent to care and treatment

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

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

Patients with a learning disability, mental health needs and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. Most of 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. For example, the 2013/14 QOF data showed 89.7% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. This was above the national average of 86.1%.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, 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 minor surgical procedures; in addition to written consent.

Health promotion and prevention

We saw that various health promotion information was available to patients and carers on the practice's website and the noticeboards in the waiting area.

The practice staff told us that opportunistic screening was mostly used for health promotion as the practice did not routinely offer a full health check to newly registered patients. This decision had been made due to an increased number of patients not attending their initial health check-up appointment. The practice offered NHS Health Checks to all its patients aged 40-75, bowel and breast screening tests and cervical screening.

Patients with long term conditions also received regular health checks for example diabetic foot screening and blood tests for people on medicines such as warfarin. Warfarin is an anticoagulant used to prevent blood clots.

A recall system was in place for following-up patients who did not attend screening and the GP was informed of all health concerns detected for follow up action. We noted a culture among the GPs to use their contact with patients to help maintain or improve their mental, physical health and wellbeing.

All patients with a learning disability, poor mental health, long terms conditions or aged 75 years and over, were offered an annual health check, including a review of their medicines. QOF data reviewed showed the percentage of patients aged 15 and over who were recorded as current

Good

Are services effective?

(for example, treatment is effective)

smokers and had a record of an offer of support and treatment was higher than the CCG area as at September 2014 (84.9% vs 69.1%). We noted the practice actively offered smoking cessation clinics to patients.

The practice's performance for cervical smear uptake in 2013/14 was 81.5%, which was in line with the national average of 81.9%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. 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.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. This was an area the practice was aware improvements were required to ensure the uptake was in line with the CCG and national averages. The practice had identified the reasons for this (inner city location and practice population demographics) and they had put an action plan in place to review and monitor this. There was a clear policy for following up non-attenders by the practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013/14 national GP patient survey and the practice surveys. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

For example, 80% of 115 patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern, and 83% said that they were good at listening. 88% of respondents also said the last nurse they saw or spoke to was good at treating them with care and concern. These results were above the CCG regional average. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with the survey information.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful, polite and caring. They said staff treated them with dignity and respect. We also spoke with eleven patients and most of them 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. We observed that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. One patient told us when they want to discuss confidential information they were offered a piece of paper to write their concerns and / or a separate room to discuss it further. We saw that curtains were provided in consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations. 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 managers. The practice managers told us they would investigate these and any learning identified would be shared with staff.

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 2013/14 national patient survey showed 80% of practice respondents said the GP involved them in care decisions and 82% felt the GP was good at explaining treatment and results. These results were aligned with the patient feedback we received.

For example, patients told us their 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.

Staff told us that patients with long term conditions, learning disabilities, poor mental health and over 75 years of age were offered an annual health check-up, including a review of their medicines. This check-up also formed basis for reviewing the patient's care plan.

We reviewed an example of a care plan for each of the following population groups to corroborate the care planning arrangements in place and patient involvement: mental health; long term condition, end of life care, substance misuse and safeguarding. The care plans showed individual patient's were involved in making decisions about their care including carers / family members where appropriate.

For example, personalised care plans included information relating to the patients preferred: communication needs, consent decision to information sharing, preferred place of

care and end of life arrangements. Where appropriate, identified risks were documented to determine the level of care and support required and to ensure the individual's safety and welfare.

Patient/carer support to cope emotionally with care and treatment

Most of the patient feedback we received showed patients received appropriate information and support to cope emotionally with their health condition and treatment. Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. Staff were described as being compassionate and understanding when individual patients needed help.

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.

The practice's computer system alerted GPs if a patient was a carer to enable the staff to offer them support. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We found importance was given to supporting carers to care for their relatives and ensuring their own health needs were met.

For example, the practice had undertaken an audit to determine the number of registered carers in the practice and their access to primary carer support service by City Care Nottingham. The information collected was then used to inform the annual recall of registered carers to attend a review of their health care needs. The practice also recognised the support needs of young carers and older people who were at risk of isolation due to living alone at home, and appropriate support was provided to address this.

The practice assessed patients with long-term conditions and multiple health needs for anxiety and depression. The self-management of mental health needs was encouraged; including referrals to Nottingham Recovery college whereby patients could attend a range of courses. This included: fighting depression beyond medication, anxiety management, building self-confidence as well as access to books on prescription. The books on prescription scheme is a national scheme designed to help patients manage their mental wellbeing using cognitive behavioural therapy-based self-help books, all written by experts. The scheme is endorsed by health professionals and supported by public libraries.

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 patient's needs and had systems in place to maintain the level of service provided. The practice engaged with the NHS England Area Team, Nottingham City Clinical Commissioning Group (CCG) 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. A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

A priority area within the local CCG included reducing avoidable hospital admissions. We saw that GPs used clinical audits and risk tools to identify patients at risk. These included older people with multiple health needs, children with minor illnesses or injury, and patients who frequently attended accident and emergency (A&E).

Records reviewed showed the practice had implemented and regularly reviewed the following arrangements to minimise avoidable A&E attendance: care plans for identified patients, use of the triage system to assess urgent and non-urgent care needs and multi-disciplinary working. This included targeted work with the community matron for patients' with complex health needs to ensure patients continued to receive care within their own homes.

The practice worked collaboratively with other services and regularly shared information to ensure good and timely communication of changes in care and treatment. Information for those patients that had attended services such as A&E, outpatient clinics and out of hours was shared electronically and acted upon by GPs. A system was in place that scanned these records onto individual patient records to ensure continuity of care.

The practice provided a wide range of services to meet the needs of each of the six population groups we inspected. For example, patients experiencing poor mental health received an annual review of their physical and mental health; and had access to an onsite counselling service.

The practice was also involved in a pilot project where suitable patients were being signposted to undertake a web-based self-counselling course. This included self-help cognitive behavioural therapy (CBT); which is a talking therapy that can help patients manage their problems by changing the way they think and behave. The uptake and effectiveness of this was yet to be audited to determine the impact on patient care. However, one patient we spoke with told us they had received excellent care and support in relation to their depression.

Patients could access community clinics for substance misuse, podiatry, and physiotherapy within the health centre. This enabled them to receive multi-disciplinary care close to home. Non registered patients could access phlebotomy, treatment room services, ear irrigation, electrocardiogram testing (ECG records the electrical activity of the heart) and h-pylori breath testing following an appropriate referral under the any qualified provider (AQP) services.

Staff gave examples of how the practice liaised with local pharmacies to ensure patients needing seven day medicine blister packs received them in time to take their medicines, as well as the use of assistive technology in sending text reminders for taking medicines.

We found coordinated care and treatment was in place for mothers, children and young people. This included access to: antenatal clinics, six to eight week baby checks and immunisation. A health professional we spoke with told us they had urgent access to GPs and the practice had consistently been responsive to any actions required to ensure positive outcomes for children.

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, longer appointments were available for patients who needed them including patients with learning difficulties and / or long term conditions. This allowed enough time to discuss their health concerns. Patients over 75 years had a named GP and home visits were offered to patients who were not well enough to attend the surgery.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG). The PRG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. For example, the following measures were put in

Good

Are services responsive to people's needs?

(for example, to feedback?)

place in response to patient concerns about phone access: discussions were held with the telephone provider regarding improving the call queuing system, staff received training in telephone etiquette and prompt phone answering, and a telephone protocol was developed to ensure consistency amongst staff.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services; and worked with other health and social care services to understand the diverse needs of patients. For example, the practice had access to online and telephone translation services for patients whose first language was not English; and deaf people could access type talk or British sign language (BSL). Type talk is the national telephone relay service which enables people who are deaf or have difficulties with speech or hearing to communicate with hearing people using the telephone network.

Information on the practice website including the role of NHS could be translated into other languages. The information was available in 20 different languages and was relevant to newly-arrived patients to the UK including those seeking asylum. The information covered issues such as the role of GPs, their function as gatekeepers to the health services, how to register as a patient and how to access emergency services. Staff told us patients who lived within their practice boundary were registered irrespective of age, race, culture, religion, disability or sexual preference.

We saw that a system was in place for flagging vulnerability in individual patient records to ensure they received appropriate care. This included children and families at risk of abuse, carers and patients receiving palliative care. Where appropriate, patient health needs were discussed in multi-disciplinary team meetings to ensure personalised and responsive care.

Letters inviting patients with learning disabilities for their annual reviews was available in easy read format to ensure patients could understand the information. Travellers from a local site were able to register with the practice as registration arrangements were flexible.

The premises and services had been adapted to meet the needs of patients with disabilities. All patient services were available on the ground floor of the practice. 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. The practice described itself as a breast feeding friendly service and appropriate facilities were in place. Chairs with armrests had been purchased and placed in the waiting area in response to patient feedback.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was discussed at staff appraisals and team events. The practice had a mix of female and male GPs which allowed patients to see a GP of their preferred gender. However, results from the 2013/14 national patient survey showed that 52% of respondents reported being able to see a preferred GP, which was lower than the CCG average of 60 %.

Access to the service

Most patients said they were generally satisfied with the appointment system. Comments received showed patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice; and this was supported by our review of the appointment system.

Most patients we spoke with told us they were able to get an appointment or were offered a telephone consultation, where needed. They also said they could see another doctor if there was a wait to see the doctor of their choice. However, some patients reported a one to two week waiting time to see a GP for a routine appointment.

This feedback was reflected in the 2013/2014 national GP patient survey which was responded to by 115 respondents. 73% of respondents described their experience of making an appointment as good; 84% found it easy to get through by phone (CCG average 75%) and 97% of respondents said the last appointment they got was convenient (CCG average: 91%). These values were above the CCG average.

Comprehensive information was available to patients about appointments on the practice website, newsletter

Good

Are services responsive to people's needs?

(for example, to feedback?)

and in the practice. We saw that patients were able to book an appointment in person, on line or through patient partner (an automated telephone appointment booking system).

We found routine appointments were available between 8:30am and 6:00pm from Monday to Friday. Extended opening hours were available between 8am to 11am every other Saturday, and 7:20am and 8:00am on Tuesdays.

Reception staff told us they sought to meet the needs of patients as flexibly as possible. For example, offering daytime appointments for patients who were able to access them and prioritising early morning or late afternoon appointments for parents with school age children or patients with work commitments.

We found the appointment system and telephone response times were monitored regularly with input from the PRG. Patient feedback, survey results and quantitative audits relating to the number of appointments offered and their outcome were discussed during the practice staff away days. This was to encourage service improvement in relation to accessing the service and ensured a practice wide approach in responding to patients' needs in a timely manner.

For example, a home visiting protocol had been developed to guide staff in prioritising home requests for patients nearing the end of their life and patients those who were housebound. GPs could also book follow-up appointments to ensure continuity of care when they needed to review a patient after a given period.

We saw that a triage system was in place to prioritise emergency appointments or phone consultations for patients. This system was nurse led and operated between 8am and 12:30pm; and 12:30 to 5pm. Patients received a call back from a GP or a nurse practitioner within two hours of contact. If a patient's need was assessed as being urgent they were seen by the advanced nurse practitioner for minor illnesses and a GP otherwise.

Our discussions with nurses showed a regular review of the triage system was undertaken. The review identified the number of appointments offered by the GP and nurse appointments. This helped the practice to plan future appointments and enabled GPs to see at least six extra patients daily. The practice analysis also showed that about 25% of triaged calls were for minor illnesses and 25% of patients received same day GP appointments on average.

The 2013/14 national patient survey showed 78% of 115 respondents were satisfied with the surgery's opening hours and 47% said they did not normally have to wait too long to be seen. On the afternoon of our inspection we noted there was a one week wait to be seen by the nurse for a long term condition and patients could book four weeks in advance to be seen by the nurse.

There were arrangements in place 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.

Listening and learning from concerns and complaints

We found the practice had a system in place for handling complaints and concerns. The practice manager was responsible for handling all complaints and ensuring that an investigation was carried out when appropriate. We looked at 28 complaints received within the last 12 months and found they had been taken seriously, responded to in a timely way and a written apology given where the practice was at fault.

We saw that information was available to help patients understand the complaints system. This included a notice in the practice reception area, information on the website and practice leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. Two patients we spoke with told us they had made a complaint and this had been acted on.

The practice reviewed complaints annually to detect themes, trends or improvements. The 2014 annual complaints review report showed no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements noted. For example, complaints against reception staff had reduced from five in 2013 to one in 2014. The practice had attributed this improvement to successful follow-up through the appraisal process and improved staff training and development.

Staff told us there was an open and transparent culture in how complaints were dealt with and reported to the CCG.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Minutes of team meetings reviewed showed complaints were discussed to ensure staff were able to learn and contribute to any improvement action that might be required.

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. This included specific goals and strategies to improve patient care. For example, participating in pilot projects aimed at developing innovative ways of delivering care, and the review of succession and workforce planning arrangements.

The July 2014 meeting minutes showed the management had discussed the staffing arrangements for clinical and non-clinical staff; taking into account patient demand on the service, training and development activities; and ways of achieving efficiencies in the delivery of the service. The minutes also detailed the actions to be taken and by whom to ensure accountability in providing feedback on progress made.

The management team told us sufficient time was devoted to the leadership of the practice including the areas of clinical practice and business planning. This was facilitated by regular meetings which included: weekly management meetings where external stakeholders were invited; monthly practice staff meetings; ad hoc and weekly GP meetings.

Records reviewed showed the practice vision and values were informed by feedback received from patients, staff and the Nottingham City Clinical Commissioning Group (CCG) for example. A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

The practice values included treating patients with dignity, respect, and ensuring they received safe care and treatment. Most of the staff we spoke with knew and understood the vision and values, and felt the practice was well-led. Team away days were held annually and provided staff with the opportunity to evaluate the progress made against the vision and promote its ownership.

Governance arrangements

The practice had a clear leadership structure in place with named members of staff in lead roles. For example, there was a lead nurse for infection control, and the GP partners were leads for clinical governance, safeguarding information governance, and health and safety. We spoke with thirteen members of staff and all were 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 had effective governance frameworks in place which focused on delivering high quality care. This included: the use of policies and procedures to govern the practice's activities; joint working arrangements with other health care providers; and using information sources to monitor performance and patient outcomes.

The practice policies were available to staff to support them in their roles and staff we spoke with knew where to find these if required. All of the policies we looked at had been reviewed and were up to date. The practice should consider reviewing the management of staff and human resources records, as these were held by three different managers and could be centralised to ensure ease of access and review.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance and one of the GPs took a lead in this area. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice had achieved 95.4% out of 100% for its total QOF points in 2013/14; and this was 3.4% above the CCG average and 1.9% above the England average. We saw that QOF data was regularly discussed at 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, the practice participated in a CCG review of diabetic patients in 2012/13 and a re-audit was completed in 2013/14. The re-audit found improvements in the care provided for these patients and this included increased input from the diabetes specialist nurse attached to the practice. The protocol for managing diabetes and the template used during annual reviews were also updated as a result of the audit to ensure patients received safe care.

The GPs told us about a local peer review system they took part in with neighbouring GP practices. Records of the peer review meetings showed the practice had the opportunity

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to measure its service against others and identify areas for improvement. For example, the practice had compared its data on emergency admissions for the following population groups: children and adult respiratory admissions, as well as gastroenterology admissions.

Gastroenterology involves the diagnosis and management of patients with diseases of the gut / digestive system. Improvement areas included: reviewing patient notes to ensure they were receiving evidence based care, making appropriate referrals to the respiratory rapid response service and routinely checking oxygen levels when visiting patients in their homes. We saw that a second clinical audit had also been completed to ensure changes to treatment were made where needed and that patient health outcomes had improved.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log which addressed a wide range of potential issues. For example verbal complaints from patients, safeguarding alerts flagged up on the system and staffing shortages. We saw that risks were regularly discussed at team meetings and updated in a timely way.

Risk assessments had been carried out where risks were identified and most action plans had been produced and implemented. This included risk assessments for fire and health and safety. The practice held monthly governance meetings and minutes reviewed showed performance, quality and risks had been discussed.

Leadership, openness and transparency

Staff told us there was an open culture within the practice and they were happy to raise issues at team meetings. This was confirmed by a range of meeting minutes we reviewed. Social events for staff were also facilitated to promote morale, positive wellbeing and informal feedback in a relaxed setting.

Staff reported being open to change as the practice actively sought improvement in the delivery of its health services. For example, the practice was investigating “doctor first”, a demand led system that allows practices to effectively manage patient demand by clinicians talking to all patients and assessing on a clinical priority basis.

The management team described the practice as forward thinking with enthusiastic staff keen to meet patient needs. This included being open and transparent about areas requiring improvement and sustainability of services offered. For example, some of the challenges faced by the practice in 2013/14 included: increasing patient demand, pressure on appointments, difficulty in recruiting clinical staff and low immunisation uptake rates (as a result of increased unattended appointments due to the inner city location).

Meeting minutes we looked at showed clear evidence of the discussions held and agreed actions to address the issues. For example, the practice had withdrawn from providing support to two care homes as part of the enhanced service due to capacity and workforce issues. However, adequate care was still provided for registered patients and the older people population group.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, the practice newsletter, comment cards and complaints received. An active patient representation group (PRG) was in place and patients were contacted via email, post or telephone. The PRG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Face to face meetings were not held as there had been limited interest in having a formal meeting. This was despite a range of initiatives and attempts to engage the practice population in joining the PRG. The initiatives included: tea and chat session over an eight week period in 2013, advertising in the practice newsletter, posters in the reception and Jayex board (call screen for clinicians to call patients to the room). The PRG included representatives from the working age and older people population groups.

The deputy practice manager showed us the analysis of the 2012/13 and 2013/14 patient surveys, which had been considered in conjunction with the PRG. The focus area of the 2013/14 survey was in relation to appointment booking and continuity of care. We noted that the practice had implemented the following changes following patient feedback: a facebook page was set up to promote information sharing and the triage system was promoted to patients in the practice newsletter. Patients had access to the monthly practice newsletter by signing up and it included information about service delivery and also invited patient comments to improve the service.

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We spoke to seven members of the PRG and most of their comments were positive about the management of the practice and it being well-led. The 2013/14 national GP survey results showed 96% of 115 respondents had confidence and trust in the last nurse they saw or spoke to and 93% in relation to GPs.

The practice gathered feedback from staff through away days, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. There were clear communication systems in place and a range of regular staff meetings were held. The practice had a whistleblowing policy which was available to all staff and staff we spoke with had no cause to use it.

Management lead through learning and improvement

The practice had an in-house educational programme for staff and staff told us they were supported to maintain their professional development through training and mentoring. Minutes of meetings we reviewed showed peer led discussions were facilitated amongst the GPs following: clinical audit findings, changes in clinical guidance and reviews of complex patient health needs. Complaints and significant incidents were shared with staff at practice meetings to ensure the practice improved outcomes for patients. However a few staff stated complaints were only shared with them if they were relevant to their roles.

Administrative staff we spoke with told us their training needs were discussed through supervision and appraisal. This was reflected in the staff files we looked at as they included training and development plans. Staff said they were supported and encouraged to develop their knowledge and skills; and this included protected learning time. We noted that nursing staff appraisals were overdue for completion and this had been planned for December 2014.

The practice was involved in the training of foundation year two doctors. The foundation programme is a two-year generic training programme which forms the bridge between medical school and general practice training.