Victoria & Mapperley Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 03 November 2014, as part of our new comprehensive inspection programme. The practice had not previously been inspected.

The overall rating for this service is good.

Our key findings were as follows:

- The staff team were committed to meeting patients' diverse needs and placed their best interests at the centre of everything they did.
- Patients expressed high levels of satisfaction with the care and service they received.
- Patients received effective care and treatment. They were also treated with kindness, dignity and respect.
- Systems were in place to keep patients safe and to protect them from harm. However, robust procedures were not always followed in practice in respect of staff recruitment, infection control and chaperone duties. Following the inspection, we received written assurances that these issues had been addressed.
- The practice responded to patients' needs. The appointment system was flexible and enabled patients to access care and treatment when they needed it.
- Staff felt valued, well supported, and involved in decisions about the practice. There was strong teamwork and a commitment to improving the quality of care and services for patients.
- The practice had undergone considerable changes in the last 18 months, which had affected the ability to drive improvements and oversee the quality of services provided.

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

The provider should:

- Ensure that the learning and improvements from significant events are shared with all relevant staff.
- Review the recruitment policy to ensure that information required by law is obtained prior to staff commencing employment at the practice.

Summary of findings

- Keep essential records to show that all nurses and GPs are registered to practice with the relevant professional body prior to their employment, and remain registered and fit to practice.
- Keep essential records to show that all relevant staff are protected from Hepatitis B infection.
- Provide a designated person to lead on infection control. Ensure systems are in place to monitor the prevention and control of infection and that policies are being followed appropriately.
- Ensure all staff receive sufficient training to enable them to undertake their specific roles.
- Ensure that arrangements are in place to enable people whose first language is not English, to access information about services.

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. There were enough staff to keep people safe. Arrangements were in place to ensure that the practice was clean, safe and adequately maintained. The practice was open and transparent when things went wrong. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.

Learning took place and appropriate action was taken to minimise risks. We found that systems were in place to keep patients safe and to protect them from harm. However, robust procedures were not always followed in practice in respect of staff recruitment, infection control and chaperone duties. Following the inspection, we received written assurances that these issues had been addressed.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice had an established staff team, who ensured continuity of care and services. Staff worked with partner health and social care services to meet patients' needs. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. Patients were regularly reviewed to assess the effectiveness of their care and treatment. Clinical audits were carried out to monitor and improve the care and outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients described the staff as friendly and caring and said that they were treated with respect. Patients were involved in decisions about their health and treatment, and their wishes were respected. Staff supported patients to cope emotionally with their health and condition. People were supported to manage their own health and care and to maintain their independence, where possible. Patients' privacy, dignity and confidentially were maintained; staff were respectful and polite when dealing with patients.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had an established staff team, providing continuity of care and access to appointments. The appointment system was flexible. Patients were able to get an appointment, or were offered a telephone consultation, where needed. The services were planned

Summary of findings

and delivered in a way that met the needs of the local population. There was a culture of openness and people were encouraged to raise concerns. Patients concerns and complaints were listened to and used to improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led. Patients told us they were asked for their views, and their feedback was acted on to improve the service. The PPG was re-established in July 2014 and was working with the practice to improve the services.

Staff said that they felt valued, well supported, and involved in decisions about the practice. There was strong teamwork and a commitment to improving the quality of care and services for patients. The practice had undergone considerable changes in the last 18 months, which had affected the ability to drive improvements. Various systems were in place to assess and manage risks and to monitor the quality of services provided. However, there were areas where robust systems were not in place to drive improvements and provide assurances that policies were being followed. Following the inspection, we received assurances that the monitoring arrangements had been strengthened to oversee all aspects of the service.

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. All patients 75 years and over were allocated a named GP to provide continuity of care, and were also offered an annual health check. Care plans were provided for patients over 75 years who had complex needs or were at high risk, to help avoid unplanned admissions to hospital.

The practice kept a register of older people who were identified as requiring additional support, and monthly multi-disciplinary meetings were held to discuss patients' needs. Carers were identified and supported to care for older people. Home visits were carried out for elderly housebound patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. All patients were offered an annual review including a review of their medication, to check that their health needs were being met. When needed, longer appointments and home visits were available. Where possible, patients' long term conditions and any other needs were reviewed at a single appointment, rather than having to attend various reviews. Patients with complex needs had a named GP to provide continuity of care. Referrals to specialists and other secondary services were made in an appropriate and timely way. Emergency processes were in place for patients who had a sudden deterioration in their health.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children and young people who were vulnerable or at risk. Immunisation rates were high for all standard childhood immunisations. The practice worked in partnership with midwives, health visitors and school nurses. A weekly baby clinic was held at the practice. Appointments were available outside of school hours to enable children to attend. The practice shared the building with a contraception and sexual health clinic, which offered direct access to teenage clinics, contraception and sexual health screening.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of the working-age people. The practice provided extended opening hours to enable patients to attend on a Saturday morning. Patients were also offered telephone consultations and were able to book non urgent appointments around their working day by telephone or on line.

The practice offered a 'choose and book' service for patients referred to secondary services, which provided greater flexibility over when and where their test took place. This enabled patients to choose which hospital or clinic they wished to be seen in, and to book their own outpatient appointments, where able. NHS health checks were offered to patients aged 40 to 74 years, which provided an opportunity to review their health needs and to identify early signs of medical conditions. The practice also offered health promotion and screening appropriate to the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with learning disabilities. Patients with a learning disability were invited to attend an annual health review. A significant number of patients at the practice had a learning disability. The clinical staff were able to demonstrate extensive knowledge, skills and understanding of patients' needs. They worked with local care homes and the learning disability health facilitator, to provide innovative ways of meeting individual's needs. A weekly substance misuse clinic was held at the practice, which one of the GPs ran.

Patients in vulnerable circumstances were discussed at monthly multi-disciplinary meetings to ensure they received appropriate care and support. When needed, longer appointments and home visits were available. Carers were identified and offered support, including signposting them to external agencies.

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. The practice held a register of patients experiencing poor mental health. Patients were invited to attend an annual health check. The practice worked with mental health and social care services to ensure that patients' needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients were supported to access emergency care and treatment when experiencing a mental health crisis.

Summary of findings

What people who use the service say

Prior to the inspection, we received comment cards from four patients. We also spoke with five patients including three members of the Patient Participation Group (PPG). The patient participation group are a group of patients who work with the practice staff to represent the interests and views of patients, to improve the service provided to them.

Patients expressed a high level of satisfaction about their care and treatment and the way the services were provided. They said that they were usually able to get an appointment, or were offered a telephone consultation, where needed. They were also involved in decisions about their care and treatment.

Patients considered that the premises were clean, and that the facilities were accessible and appropriate for their needs. They described the staff as friendly and caring, and felt that they treated them with dignity and respect. They also said that they felt listened to, and able to raise any concerns with staff if they were unhappy with their care or the service.

We also spoke with senior staff at three care homes where patients were registered with the practice**.** They praised the care and service patients received**.** They said that patients were promptly seen and their needs were regularly reviewed.

Records showed that the practice/PPG carried out a patient survey in February 2012. The responses were mostly positive; 89% of people said that they were happy with the service. The practice planned to carry out a further survey in 2015.

Representatives from the PPG told us the group had recently re-formed, and was working with the practice to improve the service for patients. For example, patients had expressed the need for further information on the extended hours and the out-of-hours service, and this had been provided. The practice's website had also been updated and photographs of staff were being displayed.

We looked at the 2014 national GP survey, which 118 patients completed. The findings were compared to the regional average for other practices in the local area. The practice scored highest in the following areas; patients usually got to see or speak to their preferred GP, and the last GP they saw or spoke to was good at involving them in decisions about their care and at explaining tests and treatments. The practice scored lowest in the following areas; patients experience of making an appointment and getting through to the surgery by phone.

Areas for improvement

Action the service SHOULD take to improve

Ensure that the learning and improvements from significant events are shared with all relevant staff.

Review the recruitment policy to ensure that information required by law is obtained prior to staff commencing employment at the practice.

Keep essential records to show that all nurses and GPs are registered to practice with the relevant professional body prior to their employment, and remain registered and fit to practice.

Keep essential records to show that all relevant staff are protected from Hepatitis B infection.

Provide a designated person to lead on infection control. Ensure systems are in place to monitor the prevention and control of infection and that policies are being followed appropriately.

Ensure all staff receive sufficient training to enable them to undertake their specific roles.

Ensure that arrangements are in place to enable people whose first language is not English, to access information about services.

Victoria & Mapperley Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP, practice manager and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Background to Victoria & Mapperley Practice

Victoria and Mapperley Practice is a partnership between seven GPs, providing primary medical services to approximately 7,800 patients across two locations in the inner city of Nottingham and Mapperley. Approximately 2,800 of these patients use the Victoria and Mapperley Health Centre as their main surgery, although all patients may access primary medical services at both locations. Mapperley Practice is registered as a separate location. We did not visit this practice as part of this inspection.

Victoria and Mapperley Practice provides a range of services including minor surgery, minor injuries, family planning, maternity care, blood testing, vaccinations and various clinics for patients with long term conditions. It is a practice for doctors in training.

The staff team includes seven GP partners, a lead nurse, two practice nurses, a treatment room nurse, a health care assistant, eight administrative staff, two office managers, a practice manager and a deputy practice manager, most of whom work across the two practices. Two GPs are male.

The practice holds the General Medical Services (GMS) contract with the NHS to deliver essential primary care services. The practice opted out of providing the out-of-hours services to their own patients. Information was available on the website and on the practice answer phone advising patients of how to contact the out of hours service outside of practice opening hours.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions. The practice had not previously been inspected and that was why we included them. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also spoke with three partner health and social care services who worked closely with the practice.

We carried out an announced visit on 03 November 2014. During our visit we checked the premises and the practice's records. We spoke with the lead nurse, a practice nurse,

Detailed findings

three GP's, reception and clerical staff, the practice manager and the deputy practice manager. We also received comments cards and spoke with patients and representatives who used the service.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

Patients told us they felt safe when using the service. Records showed that safety incidents and concerns were appropriately dealt with. Risks to patients were assessed and appropriately managed. A system was in place to ensure that staff were aware of national patient safety alerts (NPSA) and relevant safety issues, and where action needed to be taken. NPSA are managed by a central team in England, which forwards information about safety incidents to all NHS organisations to help ensure the safety of patients.

We reviewed incident reports and minutes of meetings for the last 12 months**.** This showed the practice had managed incidents consistently over time, and so could evidence a safe track record.

Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, staff had identified that a patient's abnormal test results had not been followed up. This was reported, the patient was informed and treated and more robust systems were put in place to ensure that abnormal results were acted on.

Learning and improvement from safety incidents

Staff told us that the practice was open and transparent when things went wrong. We saw that a system was in place for reporting, investigating and monitoring incidents, accidents and significant events. Significant event analysis is used by practices to reflect on individual cases and where necessary, make changes to improve the quality and safety of care. Records of incidents and events that had occurred were kept for a minimum of 10 years.

We looked at four recent significant events. These were completed in a comprehensive and timely way, and included action taken. Records showed that appropriate learning and improvements had taken place. For example, staff had identified that a test had been carried out on a patient using out-of-date equipment. This was reported, investigated and followed up with relevant staff to address the error and prevent further incidents. The test was repeated and checks were put in place to ensure that all equipment remained in-date.

The minutes of recent business meetings showed that significant events were discussed. The practice manager and the GP partners attended the meetings. A system was not in place for ensuring that the learning from significant events was shared with all relevant staff. One nurse told us that the learning was not shared with them.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Records showed that all staff had received safeguarding training specific to their role. For example, all GPs had completed level three training. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to share information, record safeguarding concerns and contact the relevant agencies.

Staff showed us the system in place to highlight vulnerable patients on the practice's electronic records system, including children and young people who were looked after, or on a child protection plan. The alert system ensured that they were clearly identified and reviewed, and that staff were aware of any relevant issues when patients attended appointments, or contacted the practice.

One of the GPs was appointed as the lead in safeguarding vulnerable adults and children. Staff we spoke with were aware of who to speak to if they had a safeguarding concern. The lead GP for safeguarding was aware of vulnerable children and adults registered with the practice. Records showed that the practice worked with relevant professionals and partner agencies such as children's social care and their health visitor and midwife to share essential information about vulnerable children. They met at regular intervals to discuss safeguarding issues to ensure that vulnerable patients were safe and protected from harm.

A chaperone policy was in place, which was visible in the waiting area and consulting rooms. The policy referred to the need for non-clinical staff to receive appropriate training to undertake chaperone duties. One of the reception staff said that they carried out chaperone duties on occasions, which indicated that they met the criteria for a disclosure and barring (DBS) check. A DBS check helps prevent unsuitable people, from working with vulnerable people, including children.

The staff member was not clear as to their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination. The practice manager

confirmed that a satisfactory DBS check had not been obtained in regards to non-clinical staff; this had recently been applied for. Staff had also not received formal training to enable them to carry out chaperone duties effectively. They agreed to ensure that non-clinical staff did not carry out the above duties, until a satisfactory DBS check had been obtained and they had received appropriate training.

We saw that patients' individual records were managed in a way to keep people safe. The practice's electronic system held essential information about patients' health and welfare.

Medicines Management

Several patients and representatives told us that the system for obtaining repeat prescriptions generally worked well, to enable them to obtain further supplies of medicines. There were plans to introduce electronic prescribing to further improve medication safety, prescribing, efficiency and access to medicines. This will enable the practice to send a patient's prescription electronically to a pharmacy of their choice, saving the patient time.

Systems were in place to ensure that medicines were managed safely and appropriately. We found that medicines were stored securely. Policies and procedures were in place to protect patients against the risks associated with the unsafe use of medicines. For example, regular checks were carried out to ensure that medicines were within their expiry date and suitable for use. All the medicines we checked were in date. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that arrangements were in place to ensure that the prescription forms were kept secure, and to ensure the security of those being collected. We saw a recent email from a GP, which identified a number of patients who had not had certain medicines reviewed for several years. Following the inspection, we received assurances that these related to minor medicines such as creams, which have since been reviewed.

A system was in place to oversee the management of high risk medicines. The practice worked with the Clinical Commissioning Group (CCG) medicines team, to ensure that patients' medicines were managed safely. A member of staff from the medicines team regularly visited the practice and carried out audits, to check that medicines were prescribed appropriately.

Cleanliness & Infection Control

We observed the premises were visibly clean and tidy. Cleaning schedules were in place and cleaning records were kept, to ensure that the practice was hygienic. Several patients told us they always found the practice clean and had no concerns about cleanliness.

We saw that the infection control policy covered essential aspects of infection control, and had been reviewed recently. Records showed that the cleaning provider carried out regular checks to monitor the standard of cleanliness, and ensure that appropriate practices were being followed. They also completed an infection audit on 11 August 2014, which was due to be re-audited in November 2018. The practice received a copy of the above reports, and shared the findings and any remedial actions with the staff team. However, the practice did not complete their own regular checks or audits to provide assurances as to the standard of cleanliness. The practice manager agreed to review this.

Senior managers told us that the senior nurse was the lead for infection control. However, the nurse said that she did not undertake this role. It is essential that the practice has a designated person to lead on infection control and oversee the standards. Staff we spoke with said they had received training on infection control and hand washing. Records we looked at showed that several staff had received recent training. The remaining staff were due to attend refresher training on 18 November 2014.

Staff had access to the procedures and personal protective equipment including disposable gloves, aprons and spillage kits, to enable them to apply infection control measures.

We checked various stock supplies of clinical and medical items; all items were in date. Records showed that relevant staff checked the supplies at regular intervals to ensure they remained in date, were sealed where required, and were used appropriately to ensure patients' welfare.

The practice had a policy relating to the control of Legionella (bacteria found in the environment which can contaminate the water systems in buildings). Records showed that regular checks were carried out in line with their policy, to help reduce the risk of infection to staff and patients.

Following the inspection, we received a copy of the staff immunisation policy. This stated that all health workers at risk of exposure to Hepatitis B infection, which could be

acquired through their work should be immunised against this**.** However, complete records were not available during or following the inspection to show that all relevant staff were protected from Hepatitis B. The practice manager assured us that staff's immunity status had been checked; this was recorded on their pay records. We were unable to independently verify this.

Equipment

Clinical staff we spoke with confirmed that all equipment was safe to use, and that they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records showed that equipment was regularly tested and maintained, including items requiring calibration such as weighing scales. The practice was located in shared premises. Some equipment such as the wall mounted mercury sphygmometers belonged to another provider, and they were responsible for maintaining them. We received confirmation that they were checked and calibrated in March 2014. The practice manager had requested that the above equipment be removed from Victoria and Mapperley surgery, in view of safety issues relating to the use of items containing mercury.

Staffing & Recruitment

The recruitment policy did not ensure that information required by law was obtained prior to staff commencing employment at the practice. We found that robust recruitment procedures were not followed in practice to ensure that new staff were suitable to carry out the work.

We looked at two files; both staff had been employed in the last six months. Both files did not include the following information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 to ensure they were suitable to work with vulnerable adults or children: Satisfactory information about any physical or mental health conditions, which are relevant to the person's ability to carry out their work. One person's file included a gap in their employment history; there was no explanation as to the reason for this. It also did not include proof of their identity including a recent photograph.

Following the inspection, we received written assurances that the above information had been obtained. We will review recruitment procedures at the next inspection.

The recruitment policy stated that applicants were required to complete an application form. However, both staff files included a copy of their curriculum vitae (CV), which contained limited information to support their suitability to carry out the work. Following the inspection, the practice manager told us that further staff applying for a position would be required to complete an application form.

A policy for checking nurses and GPs qualifications and registration to practice was available. The practice manager assured us that she followed the policy. However, records were not available during or following the inspection to clearly show this. She agreed to address this issue.

In the last 18 months the practice had appointed three new GP partners to replace partners that had retired or left. A deputy practice manager was also appointed in April 2014; which was a new post to support the needs of the service. Where possible, the GPs covered each other's absences. In the event that locum cover was required, GPs who were known to the practice were used.

The practice manager told us that it had been difficult to maintain the staffing cover over recent months due to staff changes, sickness and other circumstances. However, the team had continued to provide cover to ensure sufficient staff were available to meet patients' needs. We were assured that the staffing situation was improving.

Monitoring Safety and Responding to Risk

We found that the practice had systems in place to identify and monitor various risks to patients, visitors and staff. For example, the equipment was regularly tested and maintained to ensure it was safe to use. The practice had a health and safety policy, which staff had access to. The practice manager was the health and safety representative.

The building management company was responsible for ensuring that the premises were appropriately maintained and safe. Arrangements were in place to inform them of any concerns or safety issues the practice had.

Staff were able to identify and respond to risks to patients including deteriorating health and well-being or medical emergencies. For example, emergency procedures were in place to deal with patients that experienced a sudden deterioration in health, including pregnancy complications and acutely ill children and young people and patients

Good

Are services safe?

experiencing a mental health crisis, to enable them to access urgent care and treatment. The practice also monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

We saw that the business continuity plan covered a range of emergencies that may impact on the running of the practice. A fire safety risk assessment had been completed, which included actions required to maintain fire safety. Following the inspection, we received confirmation that all staff were due to attend refresher fire training and a fire drill by 9 December 2014, to ensure they knew how to evacuate the premises and what to do in the event of a fire.

Staff we spoke with said that they had received cardiopulmonary resuscitation (CPR) training, and were able to describe the action they needed to take in the event of a medical emergency. Records showed that all staff were due to attend refresher CPR training on 4 November 2014. We saw that various emergency equipment was available including oxygen, a defibrillator, pulse oximeters and airway equipment for adults and children. A pulse oximeter is a medical device that monitors the oxygen levels of a patient's blood.

A system was in place to oversee that that the equipment was in date and appropriate to use. Clinical staff assured us that they had received training to use the above equipment.

We saw that some emergency medicines were available for GPs to use in the event of a sudden deterioration in patients' health. The senior partner told us that the GPs had reviewed essential emergency medicines they needed to keep at a meeting in September 2014. This took into account the location of the inner city practice, the nearby community pharmacy, patients' needs and where they lived and access to emergency services. Following the inspection we received a copy of the above minutes, which showed that the GPs had discussed and agreed a list of medicines they needed to keep.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with told us they received appropriate care and treatment. Comment cards we received from patients, and feedback from three care homes we spoke with supported this.

Clinical staff told us that they received updates relating to local guidelines and current best practice from their Clinical Commissioning Group (CCG). They also received guidelines electronically from the National Institute for Health and Care Excellence (NICE). The aim of the guidelines is to improve health outcomes for patients.

We saw one of the clinical staff refer to the latest guidelines in regards to a patient they had seen that day, to ensure their ongoing treatment remained appropriate. Staff said that changes to practice and NICE guidelines were discussed at clinical meetings. We did not see evidence of this in the minutes of meetings we looked at.

The practice had an established staff team who knew their patient groups well. They worked with local services and organisations to meet patients' diverse needs. The GPs and nurses had lead clinical roles relevant to their skills and knowledge, which enabled them to focus on specific conditions and to help drive improvements.

We found that patient needs were assessed and that they received effective care and treatment to meet their needs. They were referred appropriately to secondary and community care services on the basis of need.

Patients over 75 years of age, with complex needs, at risk of harm or admission to hospital or receiving end of life care had a designated GP to ensure continuity of care and treatment. A system was in place to recall older people, those in vulnerable circumstances, those with long term conditions, or experiencing poor mental for an annual health review. Records showed that regular multi-disciplinary meetings were held to review those patients' needs and care plans.

As part of their General Medical Services (GMS) contract with NHS England, the practice provided an enhanced service to help avoid unplanned hospital admissions. Enhanced services are additional services provided by GPs to meet the needs of their patients. We found that the practice worked closely with partner health and social care services, to improve outcomes for patients and enable them to remain at home, where possible.

The senior partner told us that the practice's rates for unplanned/emergency hospital admissions and A& E attendance were below the regional average for other practices in the local Clinical Commissioning Group (CCG).

Staff worked closely with the local mental health teams to ensure that patients experiencing poor mental health, received appropriate care and treatment and were regularly reviewed. Where there were signs of acute deterioration or risk, they were supported to access urgent care and treatment.

A significant number of patients at the practice had a learning disability. External staff we spoke with told us that the clinical staff had extensive knowledge and understanding of patients' needs. They worked in partnership with local care homes and the learning disability health facilitator, to provide innovative approaches to meeting individuals' needs. Patients were offered an annual health check. At the end of the review they received a copy of their health action plan in an easy read form to meet their needs.

Staff also worked closely with the designated midwife and health visitor to provide antenatal and postnatal care and support to mothers and young children. A baby clinic was held alternate weeks at the practice, which usually involved the health visitor, a practice nurse and a GP.

Babies received a new born and six week development assessment in line with the Healthy Child Programme.

Management, monitoring and improving outcomes for people

Senior staff had lead roles in monitoring and improving outcomes for patients. The GPs told us clinical audits were often linked to medicines information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The data for 2013/14 showed that the practice achieved a total of 97.5%, which was above the average score for other practices in the local Clinical Commissioning Group (CCG).

The management team made use of audit tools, peer support and clinical supervision to assess the performance

Good

Are services effective?

(for example, treatment is effective)

of clinical staff. We saw that a system was in place for completing clinical audit cycles to provide assurances as to the quality of care, and to improve the outcomes for patients.

Various audits and reviews had been completed in the last two years, and the practice was able to demonstrate the changes resulting from these. For example, an epipen (a disposable, pre-filled device that administers a medicine to treat a severe allergic reaction) audit was completed in June 2014 following the publication of new guidance. This resulted in action been taken to ensure that relevant patients had access to two epipens to use in the event of an emergency, in line with the new guidance.

The practice was registered to carry out minor surgical procedures. The registered manager acknowledged that a recent audit of surgical procedures had not been completed, to evaluate the effectiveness of the diagnosis, treatment, and the incidence of complications. They planned to carry out an audit in 2015.

Staff told us that the outcome of audits was communicated through the clinical meetings. The meetings enabled the staff to discuss clinical issues and peer review each other's practice, driving improvements in care.

Effective staffing

The majority of staff had worked at the practice a number of years, which ensured continuity of care and services. Staff told us they had received appropriate induction training to enable them to carry out their work. They also worked well together as a team. We saw that new staff completed a generic induction programme. This was not detailed or relevant to specific roles to ensure that staff received essential information to carry out their work.

Records showed that new staff received a copy of the staff handbook, which included information they needed to know. However, we found that the handbook did not include all essential information such as safeguarding and whistle blowing. There was no review date to indicate when it was last updated. The practice manager told us that it was due to be updated in the New Year.

The practice closed for half a day each month to enable all staff to receive time for learning. Staff told us that they were supported to maintain and develop their skills and knowledge, and that they attended regular essential training such as safeguarding, basic life support and infection control. Records we reviewed supported this.

Staff were due to attend refresher training on fire safety, infection control and basic life support in November 2014. Staff told us that they received an annual appraisal, which identified their learning needs and agreed action plans.

The practice manager assured us that all GPs were up to date with their professional development requirements, and had either been revalidated or had a date for revalidation. Revalidation is the process by which licensed doctors are required to regularly demonstrate that they are up to date and remain fit to practice.

The surgery was a training practice. Two GPs had undertaken training to be trainers, and other GPs were training to be clinical supervisors for doctors, who are training to be a GP. Their first GP registrar was due to join the practice in December 2014.

Working with colleagues and other services

The practice had strong links locally with other service providers to aid communication and multidisciplinary working. For example, the senior partner also worked for the out-of-hours service.

Staff worked with partner health and social care services to meet patients' needs. It was clear from discussions with staff that considerable work went into supporting people to remain at home, and receive appropriate support on discharge from hospital. For example, the practice worked closely with the community matron, care coordinator and the district nursing services to achieve this.

Information sharing

A system was in place with the local out-of-hours service to enable essential information about patients to be shared in a secure and timely manner. The practice used Emis Web, which is a centralised clinical system, which helps staff to manage patients' records effectively. All staff were trained on the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference. Electronic systems were also in place for making referrals to secondary care.

For patients requiring emergency assessment or admission to hospital from the practice, the GPs provided a printed summary record for the patient to take with them. The practice had also signed up to the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key information.

Good

Are services effective?

(for example, treatment is effective)

Electronic systems were also in place for making referrals to secondary care.

Consent to care and treatment

Patients told us that they were involved in decisions and had agreed to their care and treatment. They also said that they had the opportunity to ask questions and felt listened to. Staff told us that they obtained patients consent before they provided care or treatment. Written consent was obtained for specific interventions such as minor surgical procedures, together with a record of the possible risks and complications.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. Clinical staff understood the importance of determining if a child was 'Gillick' competent, when providing treatment and advice. (A Gillick competent child is a child under 16 who is capable of understanding implications of the proposed treatment, including the risks and alternative options).

Staff we spoke with were aware of the Mental Capacity Act (2005) and their responsibilities to act in accordance with legal requirements. However, they had not received formal training to ensure they understood the principles of the act and the safeguards. There were no plans to provide this training for all staff.

All patients receiving end of life care had a 'Right Care' plan to ensure that their wishes were respected, including decisions about resuscitation and admission to hospital. This information was available to the out-of-hours service, ambulance staff and local hospitals.

Health Promotion & Prevention

We saw that a wide range of health promotion information was available to patients and carers on the practice's website, and the noticeboards in the surgery. It was the practice's policy to offer new patients registering had an initial health check with the practice nurse. This ensured that staff had access to essential information about people's health needs, and that any tests or reviews they needed could be arranged.

The practice offered a full range of immunisations for children, travel vaccines, shingles and flu vaccinations in line with current national guidance. The 2013/14 data for immunisations showed that the practice was above average for the area CCG, and there was a system in place for following up patients who did not attend.

The practice offered NHS Health Checks to all patients aged 40 to 74 years. Patients were also encouraged to attend relevant screening programmes including bowel, breast and cervical smears. A recall system was in place for following-up patients who did not attend the screening.

All patients with a learning disability, poor mental health, long standing conditions or aged 75 years and over were offered an annual health check, including a review of their medication.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients described the staff as friendly and caring, and felt that they were treated with dignity and respect. They also said that they felt listened to and that their views and wishes were respected. Staff and patients told us that all consultations and treatments were carried out in the privacy of a suitable room.

Representatives from three care homes we spoke with where patients were registered with the practice, also said that they felt that the staff were caring and considerate and treated patients with respect.

Staff and patients highlighted various examples of staff providing a caring approach. For example, a patient living alone who did not have regular contact with family, friends or services, received a call each week from the practice manager to check they were alright as part of a multi-disciplinary decision.

The 2014 national GP survey showed that 63% of patients surveyed were satisfied with the level of privacy when speaking to receptionists at the practice. This was below the Clinical Commissioning Group (CCG) regional average.

We observed that patients were treated with dignity, respect and kindness during interactions with staff. Patients privacy and confidentially was also maintained. A sign was displayed in the reception area informing patients that they could speak privately with staff, if required. Staff told us that if they observed any instances of discriminatory or disrespectful behaviour they would raise this with the practice manager.

Care planning and involvement in decisions about care and treatment

Patients said that they felt listened to, and were supported to make decisions about their care and treatment. The 2014 national GP survey showed that 77% of people surveyed said that the last GP they last saw or spoke to, was good at involving them in decisions about their care. 84% also felt the GP was good at explaining treatment and results, and 86% felt that they were good at listening to them.

Clinical staff told us that patients at high risk of being admitted to hospital had a care plan in place to help avoid this, including elderly patients and people with complex needs or in vulnerable circumstances. The care plans included patient's end of life wishes, including decisions about resuscitation. This information was available to the out-of-hours service, ambulance staff and local hospitals. The practice used an alert system to ensure that the out-of-hours service was aware of the above patients' needs when the surgery was closed.

Staff told us that some patients attending the practice required support to make decisions about their care and treatment, including people who had dementia or a learning disability**.** We saw that patients and carers had access to information about local advocacy and support services.

Patient/carer support to cope emotionally with care and treatment

Patients said that they received support and information to cope emotionally with their condition, care or treatment. They described the staff as caring and understanding. Where able, they were supported to manage their own care and health needs, and to maintain their independence.

The 2014 national GP survey showed that patients were satisfied with the support they received from staff. For example, 83% of patients surveyed said the last GP they saw or spoke to was good at treating them with care and concern, and 88% said that they were good at listening. 86% also said that 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 computer system identified patients who had carer responsibilities to enable the staff to offer them support. We found that importance was given to supporting carers to care for relatives, including patients receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from a GP, to determine whether they needed any practical or emotional support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Senior staff at three care homes where patients were registered with the practice told us that patients were promptly seen when required. The GPs also held regular surgeries at the care homes, to ensure that patients were regularly seen and reviewed, which helped prevent health issues from becoming more serious. Where possible, the same GP visited to ensure continuity of care and treatment.

We found that the service was responsive to patients' needs. The practice provided a wide range of services to meet patients' needs, and enable them to be treated locally. The services were flexible, and were planned and delivered in a way that met the needs of the local population, with involvement of other services. For example, patients were able to have their blood tests done at the practice. Staff also carried out dressing changes, wound care and electrocardiogram (ECG) tests, which records the rhythm and the activity of a patient's heart.

Records showed that regular multi-disciplinary meetings were held, to discuss patients with complex needs or at risk, including people with poor mental health, learning disabilities or receiving end of life care. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes.

The practice was involved in the enhanced service to help provide an early diagnosis for patients who had dementia. They were also involved in the palliative care gold standards framework, which helps to provide the highest standard of care for patients who are terminally ill. The practice worked closely with local community nursing teams and the Macmillan service to ensure that patients' end of life care took account of their needs and wishes, and responded to changes in their needs.

The practice had a high prevalence of patients who had a learning disability, and two GP leads supported their needs. The clinical staff were able to demonstrate extensive knowledge, skills and understanding of patients' needs. They worked in partnership with local care homes and the learning disability health facilitator employed by NHS health services, to provide innovative ways of meeting individuals' needs. For example, a patient's annual health review was carried out at a location where they felt most at ease. They also involved health facilitators employed by NHS health services to support an individual with complex needs to have their blood pressure checked, who previously had refused to have this done.

External staff we spoke with confirmed that the practice worked in partnership with them to provide innovative approaches to meeting individual's needs.

The practice also had a high prevalence of patients who had a drug dependency. The practice had recently been awarded the contract for providing a substance misuse clinic linked with Nottingham Crime and Drugs partnership. A GP who had undertaken relevant training held a weekly substance misuse surgery at the practice. This was available to both patients who were registered with the practice and others who were not. The practice had a lead GP for mental health who worked closely with local services to support patients experiencing poor mental health.

The practice worked in partnership with midwives, health visitors and school nurses. The practice and the designated midwife and health visitor provided antenatal and postnatal care and support to young children and mothers. A baby clinic was held on alternate weeks at the practice, which usually involved the health visitors, a practice nurse and a GP.

The practice shared the building with a contraception and sexual health clinic, which offered direct access to teenage clinics, contraception and sexual health screening.

The practice had an established staff team, providing continuity of care and access to appointments. We saw that systems were also in place to ensure that patients were promptly referred to other services, where required.

Systems were also in place to ensure that test results, information from the out-of-hours service and letters from the local hospitals including discharge summaries were promptly seen, correctly coded and followed up by a GP, where required. However, we saw some actions on the system, which showed that patients had not been promptly followed up or reviewed. The registered manager agreed to review this. Following the inspection, we received written assurances that the review highlighted no risk to patients. With the exception of two tasks, actions had been taken,

Good

Are services responsive to people's needs?

(for example, to feedback?)

and that the two with no actions were from the previous day. The practice planned to review the effectiveness of the above systems at the partners meeting on the 17th November 2014.

The Patient Participation Group (PPG) had not been active since 2012. The deputy manager had taken on the lead role to help re-establish the PPG, and two recent meetings had been held. Members of the PPG said that they felt that they had the full support of the practice.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services, and worked with partner health and social care services to understand and meet patients' diverse needs. Staff informed us they operated an open list culture, accepting patients who lived within their practice boundary.

Staff told us there was a wide range of diversity within the patient population. Staff were able to describe a good awareness of culture and ethnicity issues. Records showed that various staff had received training on equality and diversity. The practice had a large number of patients whose first language was not English.

The staff were knowledgeable about language issues, and had access to language line (a telephone translator service) to obtain assistance in consultations in different languages. Staff and patients also had access to local interpreters, where required. A folder was also available in the reception to help staff to identify patients' first language if this was not clear. However, the practice's website did not have a translation facility to enable people whose first language was not English, to access the information about the services.

Records showed that home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

The premises and the facilities considered the needs of people with disabilities. For example, the facilities were accessible for people in a wheelchair, and mothers with young children in a pushchair.

Access to the service

Patients we spoke with and comments cards we received showed that patients were able to get an appointment, or were offered a telephone consultation, where needed. None of the patients we spoke with or who completed a comment card expressed difficulty in getting through to the practice by phone.

The 2013/2014 national GP survey showed that 82% of people surveyed, were able to get an appointment to see or speak to a clinician the last time they tried. Whilst 62% said that they had not found it easy to get through to the practice by phone.

Staff told us that the appointment system and telephone response times were regularly checked, to ensure that the practice responded to patients' needs. The practice manager acknowledged that these had not been formally reviewed or audited in the last two years, to provide assurances that it was meeting patients' needs. She agreed to formally review these.

Patients were able to book an appointment in person, by telephone or on line. Extended opening hours were available alternative Saturdays from 8:30 am until 12:30 pm, providing nurse led appointments with a GP on call. This enabled children and young people to attend appointments outside of school hours. It also enabled working age patients and those unable to attend on week days, to attend at the weekend.

We saw that systems were in place to prioritise emergency and home visit appointments, or phone consultations for patients who were not well enough to attend the practice. We observed staff adding patients who needed to be reviewed urgently to the GPs appointments to be seen that day, or arranging for a call back from a doctor.

Information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website. The practice had a wide range of patients of culture and ethnicity issues population is predominantly white British. Staff we spoke with were aware that they could access a translator for patients attending the practice whose first language was not English. We saw that information in different languages was available in the reception area, informing people that a translator service was available, if required.

The practice occupied the ground floor area of a shared building. We found that the facilities and the premises were accessible and were largely appropriate for the services being delivered.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

Patients said that they felt listened to and able to raise concerns about the practice. They were aware of the process to follow should they wish to make a complaint, but they had not had cause to do so.

We saw that the complaints procedure was accessible to patients on the practice's website and at the surgery. This required amending to ensure that people had access to consistent and up-to-date information. For example, the website stated that a person's complaint could also be dealt with by the local Primary Care Trust, whilst the leaflet in the practice referred people to the Health Service Ombudsman if they were not satisfied with the practice's response. There was no reference to the fact that people may direct their complaint to NHS England area team rather than the practice. The practice manager agreed to update the information.

We saw that a system was in place for handling complaints and concerns. We looked at the records of complaints received in the last 12 months. The records largely showed that concerns had been acknowledged, investigated and responded to in line with the practice's policy. However, a clear audit trail was not available in regards to certain complaints. The practice manager assured us that further information was held elsewhere. She agreed to keep a clear log and file of all complaints received to show that they had been handled in line with the NHS procedure and contractual obligations for GPs.

Staff told us that there was a culture of openness and that they were encouraged to raise concerns. They also said that complaints were shared with staff at team meetings, and were acted on to improve the service for patients. Records of meetings supported this. Staff had access to the complaints policy. Records showed that complaints were reviewed to identify any patterns and trends, and to ensure they had been responded to properly.

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 aims and values set out in the provider's statement of purpose were to provide high quality care and services to patients. Most staff we spoke with were not aware of the provider's statement of purpose or future plans for the service. However, all staff were clear that they placed the best interests and welfare of their patients at the heart of everything they did.

Records showed that regular business meetings were held, where future plans were discussed. The senior partner told us that due to recent partner changes and circumstances, the new partnership had yet to set out a business plan and clear plans for future development.

Governance Arrangements

The practice had a range of policies and procedures in place to govern the practice. These were available to staff electronically. A system was in place to ensure that the policies were regularly reviewed and were up-to-date, and that these were shared with staff.

Several policies we looked at had recently been reviewed. However, we found that certain policies were not robust to govern the practice, and ensure that staff followed the required procedures. For example, the recruitment procedure did not ensure that information required by law was obtained prior to staff commencing employment at the practice. In view of this, robust procedures were not followed in practice to ensure that new staff were suitable to carry out the work.

Records showed that the GP partners held monthly meetings to discuss the practice's business, finances, governance and performance. Regular meetings were also held to discuss clinical issues and to share best practice. Several clinical audits were completed in the last two years, which showed that appropriate action was taken to improve the quality of the service, and to ensure that patients received appropriate care and treatment.

The practice used performance data to measure their service against other practices and identify areas for improvement. This included the use of Quality and Outcomes Framework (QOF), which is a national performance tool designed to reward good practice. The 2013/14 data for this practice showed it was performing in line with, or above national standards. Records showed that the QOF data was discussed at team meetings, and action plans were produced to maintain or improve outcomes.

Senior managers demonstrated a commitment to improving the quality of care and services for patients. However, the practice had undergone considerable changes in the last 18 months, which had affected the ability to drive improvements.

Various systems were in place to monitor the quality of services, including complaints, incidents, safeguarding, and medicines management. However, we highlighted areas where robust systems were not in place to drive improvements and provide assurances that policies were being followed. Following the inspection, we received assurances that the monitoring arrangements had been strengthened to oversee all aspects of the service.

Leadership, openness and transparency

We were shown a leadership structure, which included seven GP partners, a practice manager, a deputy practice manager and four practice nurses. All senior staff had lead roles and responsibilities to ensure that the service was well led. For example, one of the partners was the lead for mental health, learning disabilities, finance, contracts and performance, whilst another partner was the lead for drugs misuse and medicines management.

Most staff we spoke with were clear about their roles and responsibilities, and felt that the practice was well led. They also said that they felt valued, well supported, and involved in decisions about the practice. Staff described the culture of the organisation as supportive and open, and felt able to raise any issues with senior managers as they were approachable. The practice manager had an 'open door' policy to discuss any concerns or suggestions.

A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it. Records showed that regular team meetings were held, which enabled staff to share information and to raise any issues.

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

The practice obtained feedback from patients through surveys and complaints. Patients said that they felt able to raise concerns, compliments or complaints with the staff. Information received was acted on, and changes were made, where possible.

Are services well-led?

Good

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

The Patient Participation Group (PPG) is a group of patients who work with the practice to represent the interests and views of patients, to improve the service provided to them. The deputy manager had taken on the lead role to help re-establish the PPG, which had not been active since 2012 and two recent meetings had been held.

Members of the PPG said that they felt that they had the full support of the practice. They were asked for their views to improve the service, and their suggestions were acted on. For example, in response to feedback the practice's website had recently been updated, and staff photographs were being displayed.

Records showed that the PPG/practice carried out a patient survey in February 2012. The responses were mostly positive; 89% of people said that they were happy with the service. The practice manager told us that they planned to carry out a further patient survey in 2015, with involvement of the PPG.

As part of GPs annual appraisal of their work, records showed that a number of patients had recently completed the General Medical Council's survey. The survey provides feedback on a GPs conduct and skills to carry out their work. We looked at four GPs survey results, which showed high levels of patient satisfaction.

Discussions with staff and records reviewed showed that the practice obtained feedback from staff through team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the quality of the services provided.

Management lead through learning & improvement

Staff told us that they were supported to maintain and develop their skills and knowledge. For example, one nurse was being supported to complete the practice nurse foundation programme to develop her knowledge and skills. Several staff records we looked at did not include evidence of all training they had received to carry out their work effectively. The practice manager agreed to address this issue.

The practice manager acknowledged for reasons that most of the non-clinical staff and two of the nursing staff who worked at the practice, had not received an annual review of their performance in the last 12 months. We were told that three staff members had received a recent appraisal, although the notes had yet to be completed.

A clear plan was not in place relating to the completion of all staff appraisals. The practice manager assured us that all staff would receive an appraisal by the end of March 2015. We were shown examples of several completed appraisals of staff that worked at the provider's other practice, which set out their performance, learning and development needs.

Records showed that accidents, incidents and significant events were reviewed to identify any patterns or issues, and that appropriate actions were taken to minimise further occurrences. Records showed that appropriate learning and improvements had taken place, and that the findings were communicated to staff.