

East Bridgford Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Requires improvement



Are services safe?

Inadequate



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at East Bridgford Medical Centre on 25 August 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice good for providing effective, caring, and responsive services. It was rated as inadequate for providing safe services and requires improvement for being well led.

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

- There were weaknesses in the system to report incidents and near misses. Information about safety was not recorded, monitored, appropriately reviewed, and addressed.
- Risks to patients were not always assessed and well managed, in particular the management and storage of medicines was not sufficient to ensure that patients were safe from harm.
- 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, however, the training plans for new staff in the dispensary needed to be strengthened.

- Patients told us they were treated with compassion, dignity, and respect and they were involved in their care and decisions about their treatment.
- Information about services offered and how to complain was available and easy to understand.
- Patients told us they could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported by management.

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

Importantly the provider must

Summary of findings

- Strengthen the system to ensure that information received from safety alerts is managed, monitored and learning shared.
- Strengthen the system that would ensure that learning from significant events, near misses and complaints was recorded, learning shared and improvements made in a timely manner
- Improve the management of medicines to ensure that patients are safe from harm. This must include robust and regular monitoring of stock levels, expiry dates and monitoring of fridge temperatures. The provider must ensure that staff investigate and report when the temperature recording are not within the correct range.

- Ensure that new staff are fully and appropriately trained to fulfil their role.
- Ensure that the storage and management of Schedule 3 drugs is consistent.

In addition the provider should

- Improve the assessment, monitoring, and mitigation of risks in the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as inadequate for providing safe services, as there are areas where it must make improvements.

Staff understood their responsibilities to raise concerns; however, they did not report all complaints, incidents, and near misses. When things went wrong, reviews and investigations were not thorough and learning was not communicated to support and sustain improvement.

The practice systems for the management of medicines and safety alerts were not robust and did not ensure that patients would be kept safe.

The practice had robust procedures for the recruitment of staff that ensured they were appropriately qualified for their role and responsibilities. The building and equipment were safe to use.

Inadequate



Are services effective?

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. The practice total points achievement in respect of the Quality and Outcomes Framework (QOF) was 95.1%; this was 1.2% above the CCG average and 2.8% above the national average.

Data showed the practice achievement in respect of females aged 25-64, attending cervical screening was 87.1% which was above the CCG average of 83.4% and the national average of 74.3%. The practice was also above the CCG and national average in respect of their performance for screening for bowel cancer.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation.

There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams with good outcomes for patients.

Good



Are services caring?

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients told us they were treated with compassion, dignity, and respect and they were involved in

Good



Summary of findings

decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

The GP Patient Survey from July 2015 showed that the practice was rated higher than other practices locally and nationally in respect of indicators related to caring. For example:

- 100% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and national average of 97%
- 100% of respondents said they had confidence and trust in the last nurse they saw compared to the CCG average of 97% and national average of 95%

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. For patients that had poor mental health the practice had access to GPs at a time that was convenient for them and without the need to book through the appointment system.

Home visits and delivery of medication was available for those patients that were unable to attend the practice. For those patients who were working the practice offered evening appointments and they offered telephone consultations at specific times. The practice had a carers' champion who had developed links with local networks and was able to signpost patients to these agencies for additional support.

Good



Are services well-led?

The practice is rated as requires improvement for being well-led.

The practice was not able to demonstrate that it had systems and processes in place that would monitor, evaluate, and share learning to give assurance that risks were managed to keep patients safe.

The practice proactively sought feedback from staff and patients, which it acted on. The patient reference group (PRG) was active and were able to confirm that they had a very good relationship with the partners and staff at the practice.

Requires improvement



Summary of findings

The practice held practice meetings each two months; however minutes from these meetings were sufficiently detailed to assure us that learning was extracted and that it translated into changes that would improve services to patients.

There was evidence of training for staff, however for the new staff; the practice did not have role specific plans for training and monitoring performance.

The practice showed innovation and commitment to the development of new services that would benefit the patients for example the practice and the local care home had plans to introduce new technology (Skype, email and video), this would benefit patients who would usually be working, could not attend the practice or those living in local care homes.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held regular meetings with the extended team of community specialists including community matrons. The practice had a system to ensure that the preferred place of care for patients was recorded and available to other agencies. The practice worked closely with the community matron who was an independent nurse prescriber, this benefitted patients as there were no delays in receiving medication in a timely way. Home visits were available for those that needed them and the practice dispensary would deliver medication to patients who were housebound or unable to attend the practice.

Data from the quality and outcome framework (QOF) showed that the practice performance in respect of conditions commonly found in older people was better than the CCG and national average:

- Performance for osteoporosis was 100%; this was 13.3% above the CCG average and 16.6% above the national average. The exception reporting in both criteria of this indicator was 0.13% and 0% this was significantly below the CCG averages of 8.7% and 17.7% and the national averages of 8.6% and 17.1%.
- Performance for stroke was 99.7% this was 2% above the CCG average and 3.4% above the national average.

Requires improvement



People with long term conditions

The practice is rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice held regular meetings with the extended team of community specialists including community matrons.

The practice offered longer appointments and home visits were available when needed, for these housebound patients the practice would deliver their medication.

Requires improvement



Summary of findings

The quality and outcome framework (QOF) data showed the practice performance was good in respect of the following conditions:

- Diabetes was 93.7%; this was 2.3% above the CCG average and 3.6% above the England average.
- Hypertension was 92.9%, this was 6.3% above the CCG and 4.5% above the England average
- Asthma was 100% this was 2.2% above the CCG average and 2.8% above the England average
- COPD was 100% this was 3.4%, above the CCG average and 4.8% the England average

We noted that the exception rating was higher than the CCG and England averages in some elements of these domains. The practice told us that they encouraged patients to attend for their appointments, however, recognised that they needed to continue to review this.

Families, children and young people

The practice is rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held regular multi-disciplinary team meetings to protect children and families where there were safeguarding concerns. The practice offered breast feeding and baby changing facilities.

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

- Under two year olds ranged from 84.9% to 98.1% which was comparable with the CCG average of 87.1% to 98.2%
- Five year olds from 95.5% to 100.00% which comparable to the CCG average of 92.2% to 100%.

Appointments were available outside of school hours. A full family planning service including long acting contraception was offered and appointments were arranged to be flexible to meet the needs of the patient.

Requires improvement



Working age people (including those recently retired and students)

The practice is rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



Summary of findings

The practice offered extended hours appointments for GPs and nurses. This allowed patients that were working to attend for pre booked appointments and health screening. The practice advertised these services, how to order repeat medication and book appointments online. The practice offered telephone consultation at specific times and the practice had plans to develop the use of new IT technology for example Skype consultation.

The practice routinely offered NHS health checks for patients aged 40-74 and a range of health prevention clinics, for example travel advice.

People whose circumstances may make them vulnerable

The practice is rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

It offered longer appointments for people with a learning disability.

The QOF data showed that the practice performance was

- For patients with learning disabilities this was 100% with no exception reporting, this was 12% above the CCG average and 9.8% above the England average.

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

The practice employed a Carers' Champion who had established local networks. The champion was able to sign post patients and carers to these agencies for extra support.

The practice did not have any homeless people or travellers registered.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as inadequate for providing safe services and requires improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Requires improvement



Summary of findings

The practice provided care to a particular group of patients with complex mental health needs. Some of these patients lived in a low security psychiatric unit and other patients lived in a care home setting.

The practice offered drop in appointments during lunchtime so that the patients from the unit could attend the surgery for routine or urgent appointments. This enabled and encouraged patients, who could otherwise be marginalised to engage with the wide range of healthcare services.

The quality and outcome framework (QOF) data showed that

- For people experiencing poor mental health had received an annual physical health check the practice performances was 95.2% this was 0.6% above the CCG average and 1.7% above the England average.
- For people with dementia the practice performance was 91.2% this was 5.2% below the CCG average and 2.2% below the England average.

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

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing above the local and national averages in most cases. There were 111 responses and a response rate of 43%.

- 90% find it easy to get through to this surgery by phone compared with a CCG average of 81% and a national average of 73%.
- 91% find the receptionists at this surgery helpful compared with a CCG average of 91% and a national average of 87%.
- 59% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 61% and a national average of 60%.
- 94% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 90% and a national average of 85%.
- 99% say the last appointment they got was convenient compared with a CCG average of 94% and a national average of 92%.
- 87% describe their experience of making an appointment as good compared with a CCG average of 80% and a national average of 73%.
- 79% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 64% and a national average of 65%.

- 63% feel they don't normally have to wait too long to be seen compared with a CCG average of 55% and a national average of 58%.

The patient reference group (PRG) consists of 12 patients, a GP representative and the Practice Manager, and they met monthly. In addition to this the practice had a 'Virtual Patient Group' of 100 people, who had agreed to be contacted via email or text message. This widened the numbers that were able to contribute thoughts, ideas and comments to improving patient care.

The practice and the patient reference group held an annual health event. This event encouraged patients to attend an informal educational event to hear from invited consultants and GPs how they could manage their own health and improve their lifestyle. These events were held on a Saturday this enabled patients who would normally be at work to attend.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 49 comment cards which were positive about the standard of care received

Areas for improvement

Action the service MUST take to improve

- Strengthen the system to ensure that information received from safety alerts is managed, monitored and learning shared.
- Strengthen the system that would ensure that learning from significant events, near misses and complaints was recorded, learning shared and improvements made in a timely manner
- Improve the management of medicines to ensure that patients are safe from harm. This must include robust and regular monitoring of stock levels, expiry dates

and monitoring of fridge temperatures. The provider must ensure that staff investigate and report when the temperature recording are not within the correct range.

- Ensure that new staff are fully and appropriately trained to fulfil their role.
- Ensure that the storage and management of Schedule 3 drugs is consistent.

Action the service SHOULD take to improve

- Improve the assessment, monitoring, and mitigation of risks in the practice.

East Bridgford Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice nurse specialist adviser, an Expert by Experience and second CQC Inspector.

Background to East Bridgford Medical Centre

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

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

The practice holds a GMS contract, has a dispensary, and is a training practice with one GP trainer. A training practice has GP registrars working in the practice; a GP registrar is a qualified doctor who is undertaking further training to become a GP. A trainer is a GP who is qualified to teach,

support, and assess GP registrars. There are currently three GP registrars working in the practice. The practice offers a range of services including sexual health, long term conditions, and travel advice.

The practice team consists of three GP partners, two male, and one female whole time equivalent (WTE) 2.75, one salaried GP and three GP registrars (WTE 2.6), three female nurses (WTE 1.9) and two health care assistants (WTE 0.75). The non-clinical team consists of one practice manager (WTE 0.97), five reception staff (WTE 3.75), and three administrative staff (WTE 2.18). The practice employs eight dispensary staff (WTE 4.18)

The practice is open between 8.00am and 6.30pm Monday to Friday. Appointments are from 8.30am to 10.30am every morning and usually 3.30 or 4.00pm to 5.30pm daily. Late surgeries are offered on some Mondays, Tuesdays, or Thursdays with appointments from 6.30 to 7.30pm.

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

Why we carried out this inspection

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

Detailed findings

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

How we carried out this inspection

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

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

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

- Older people

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

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 25 August 2015. During our visit we spoke with a range of staff including three GPs, nursing team staff, reception, administration, and dispensary staff. We also spoke with ten patients who used the service and the chair of the patient reference group. We observed how people were being cared for and reviewed the personal care or treatment records of patients. We reviewed 49 comment cards where patients and members of the public shared their views and experiences of the service. We spoke with the manager of a local care home.

Are services safe?

Our findings

Safe track record and learning

The practice was not able to demonstrate that it had a safe record over time. The system used had weaknesses which did not assure us that incidents involving patient's safety were regularly reviewed to minimise the risk of them reoccurring in the future.

For example,

staff identified a GP had prescribed an unusually high amount of a medicine for a young person. The staff member contacted the GP immediately who amended the quantity. The team did not record this event. There was no evidence to show that the GP recorded the event or recognised it as one which should be investigated.

The staff we spoke with told us that when significant events or near misses happened they would speak with the clinician or practice manager and resolve the issue but confirmed they did not always record the event for future monitoring of trends, shared learning or to prevent the same incident happening again.

The practice log for significant events showed three incidents had been recorded since April 2015. Once logged the significant events were discussed at the practice meeting, this meeting was held every two weeks. Neither the minutes nor the log contained sufficient details of any discussions, actions or learning to be shared. There was a protracted delay in sharing learning in one instance where a patient safety incident from June was not discussed until September 2015.

The practice systems used for managing safety alerts showed weaknesses and did not assure us that patients would be kept safe. For example, safety alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA) were cascaded to GPs, nurses and dispensary staff by the practice manager who received the alerts by the email system. Although staff confirmed they received the alerts they did not record or share actions taken, if any. Practice staff were unable to demonstrate that all appropriate staff received the information, carried out any actions required or shared or monitored the learning to protect patients and staff from the risk of harm.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff on the practice intranet. There was a lead GP for safeguarding and staff told us that they were able to report any concerns and were aware of their roles and responsibilities. The practice held monthly multi-disciplinary team meetings where GPs attended along with other agencies such as community nurses, health visitors, and community matrons. Staff had received training appropriate to their role. We saw examples of actions taken to protect vulnerable older people from harm.
- A notice was displayed in the waiting room, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Patients confirmed they were aware that they could ask for a chaperone.
- There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills had been carried out. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. The practice had carried out a test for legionella on 13 January 2015. The practice policy for infection control biological substances had been reviewed in December 2014.
- The safety of portable electrical appliances had been tested on 11 August 2015 and clinical equipment had been checked to ensure it was working properly.
- The premises were visibly clean and tidy. The practice had a baby change area with a changing mat area with paper couch roll for cleanliness. There was a lead for infection control who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. An annual

Are services safe?

infection control audit was undertaken 14 January 2015 and an action plan written detailing improvements needed. The practice had made some changes and other improvements had been planned.

However, the arrangements and systems used for managing medicines, including emergency drugs and vaccinations, in the practice were not robust and did not ensure patient safety.

- On 30 June 2015 a significant event was recorded on the practice log. An out of date vaccine had been administered to a patient. The vaccine was four weeks out of date. The staff took immediate action to ensure the patient was informed and they received the necessary follow up care. Staff confirmed this event had not been discussed at a practice team meeting and was not scheduled to be until September 2015 in spite of this potentially having a direct impact on patient safety to ensure learning took place.
- We observed out of date medicines stored in the treatment room fridge.
- Medicines stock levels were not robustly monitored, for example there was an excess supply of vaccine with an expiry date in eight weeks. Staff confirmed there was enough vaccine in the fridge to provide immunisations to the particular patient group for one year.
- The contents of the emergency trolley had last been checked in May 2015. We observed an out of date emergency medicine was available for use on the trolley. Staff were unable to demonstrate that they had a robust system in place to ensure effective and safe stock control.
- In the reception area, we found emergency packs ready for GPs or nurses to use in the event of a patient requiring a catheter in the community. These packs contained out of date equipment and gel that expired early in 2014. We highlighted this to the practice who removed all the packs.
- The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw PGDs that had been signed by the appropriate nurses.

We visited the practice dispensary. There was a lead GP for management of the dispensary within the practice. The practice delivered medicines to patients who would not or

could not leave their house and to those unable to attend the practice. The dispensary staff that dispensed medicines were all trained to a minimum of NVQ level two. This is the required standard for dispensary staff.

In the dispensary we identified concerns as follows:

- One of the fridges used to store drugs had been overfilled. There was not sufficient space around the contents for airflow therefore the practice could not be sure that all the vaccines were stored within the safe temperature range of two degrees to eight degrees Celsius. The practice was not able to demonstrate that the medicines were stored appropriately and that they would be safe and effective to use.
- The system we saw for checking and recording the temperature of the fridges in the dispensary and the treatment room was not sufficiently robust. On the recording sheets used by the staff, we noted that from Monday 3 August 2015 until Friday 7 August 2015, two recording sheets were being used for two different fridges. On each sheet there were only two entries made, one recording was made on 4 August 2015 and one was made on 6 August. Where the chart showed that the temperature of the fridge had exceed the upper or lower limits the staff had not recorded any action taken such as restocking or cleaning. The practice used thermometers that constantly recorded the temperature of the fridges. Staff told us that this information was checked each Friday but could not, when requested, provide evidence that confirmed this or that any action was taken when problems were identified. The electronic record from one fridge indicated the fridge temperature had reached eight degrees Celsius for one week. Staff told us it had not been reset properly and this was a training issue but the issue had not been documented or reported. The practice was not able to demonstrate that the medicines were stored appropriately and that they would be safe and effective to use
- Information from staff and records identified issues with stock control systems, which were irregular.
- A new staff in the dispensary did not have robust training plan to ensure that learning, monitoring and

Are services safe?

assessing of competency was robust. Instead they had been given a written guide of what to do. This guide was insufficient to ensure that the staff member was trained to an appropriate level.

- Although controlled drugs were stored correctly there was a lack of understanding and consistent approach towards the storage and recording of Schedule 3 drugs. (Schedule three drugs are exempt from safe custody of storage and do not need to be stored in a locked cupboard or recorded in the controlled drug register). Staff identified this as a training issue.
- Staff told us that they received safety alerts such as those from Medicines and Healthcare products Regulatory Agency (MHRA), from the practice manager through the email system and would take any actions necessary. They were unable to provide any records of neither these alerts nor any actions that had been taken and by whom.
- Dispensary staff told us that they did not keep a record of any significant events or near misses. For example, a staff member prepared to dispense a prescription to a patient, they noticed and were concerned about the quantity of drug prescribed; the staff contacted the GP who amended the prescription. The staff did not record this event for future monitoring or learning. The practice was not able to demonstrate that there was a robust system to ensure that lessons would be learnt from significant events and near misses.

We saw that blank prescription pads were storage securely.

- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For

example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. We saw that the practice worked on an appointment system that managed the demand for appointments on the day. Staff told us that GPs extended their appointments to accommodate patients who required attention or who required telephone advice. Patients who were identified as vulnerable because of their mental health were given a protected time slot to drop into the practice enabling them easier access to healthcare.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult mask but the practice did not have a paediatric mask. There was a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and most staff knew of their location.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff were familiar with current best practice guidance, and accessed guidelines from the National Institute for Care and Health Excellence (NICE) guidelines and locally produced quality standards.

The practice, on behalf of the all the practices in the Rushcliffe CCG, planned and organised training meetings where updates and good practice were shared. These meeting were held monthly and included GPs, practice and community nurses, and non-clinical staff. The attendance at the events averaged 50 clinical staff, and this was an opportunity for networking, and shared learning across the local area.

Management, monitoring and improving outcomes for people

The practice was engaged with the Clinical Commissioning Group (CCG) in several prescribing initiatives including the dispensary quality scheme and prescribing to the Nottingham Area Prescribing Committee Guidelines. The practice also uses the PINCER tool to ensure that the clinicians are alerted when there maybe contra indications of medications that are being prescribed to patients. GP practices to identify patients who are potentially at risk of harm through prescribing errors or inadequate drug monitoring. PIN The PINCER audit tool allows GP practices to

The practice told us and the care home confirmed that they had plans to work with the practice to develop an electronic version of the medication administration record (MAR) to ensure safer and more effective prescribing for patients. The practice engaged with the CCG pharmacist who attended the practice and reviewed the medications of patients to ensure compliance and cost effectiveness.

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

Data from 2013/14 showed the practice had achieved 95.2% of the total points available which was 0.6 above the CCG average and 1.7% above the national average. Some examples of practice performance included:

- In respect of diabetes related indicators the practice achieved 93.7% this was 2.3% above the CCG average of and 3.6% the national average.
- In respect of hypertension the practice achieved 92.9% this was 6.3% above the CCG average and 4.5% national average.
- In respect of mental health related indicators the practice achieved 99.2% this 4.9% above the CCG average and was 8.8% above the England average.
- Their performance in respect of dementia diagnosis was 91.2%, which was 5.2% below the CCG average and 8.8% below the national average.

We asked the practice for information on their exception reporting rates. Published data indicated the practice exception rate for patients with diabetes receiving the flu immunisations was 20.5%; this was 7.3% above the CCG average and 4.4% above the England average. The practice told us that they had opened on three Saturday mornings, however, patients did not attend and declined vaccination. They have planned to review this again.

QOF includes the concept of exception reporting. Practices are not penalised, where for example, medications cannot be prescribed due to a contraindication or side effect, or the patients refuses to attend for a review.

Since October 2013, the practice had started seven audits. We saw two complete clinical audits in the last two years, where the improvements made were implemented, and monitored, further improvements were identified. For example, an audit of minor operations documentation and outcomes. The first cycle of the audit was undertaken November 2013; the second cycle was undertaken September 2014. The results showed an improvement but in three of the four areas the results were below the standards set and further improvements had been made to the system to further improve recording consent, appropriate histology and asepsis. The practice confirmed that they intended to repeat this audit annually to ensure improvement.

Effective staffing

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge, and experience to deliver effective care and treatment. We reviewed five staff paper and electronic files and saw that,

- The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings, and reviews of practice development needs. The staff had access to on line training through the practice software. The practice had also run training events for the staff. We saw evidence that the dispensary staff were trained to a minimum of NVQ level 2, with the exception of the new team member and that staff had received training for safeguarding, fire procedures, and infection control. We were told that they did not have role specific training plans.
- Most staff had had an appraisal within the last 12 months; the appraisals for the nursing staff were planned for September as the practice had recruited a new lead nurse in June 2015.

Coordinating patient care and information sharing

The practice staff worked with other services providers to meet patients' needs and manage those patients with more complex needs. The community matron told us that the practice had worked with the CCG on an electronic system (Epact) to ensure that the patients who were at risk of unplanned admission to hospital were identified and their care preferences were documented. This initiative had led to an increased number of patients being identified from 29% to 63%. Information about the patient choice was shared with the providers of out of hours care to allow patients who may be nearing the end of life to be cared for in their preferred place.

We saw minutes of the monthly meeting which demonstrated clinicians discussed and agreed care plans for patients who were at risk of admission or the those children and young families where there were concerns. These multi disciplinary team meetings (MDT) were attended by GPs, community nurses, matron, health visitors and care co-ordinators. For example, there were

concerns raised by staff that a patient with a young child was frightened and scared. Appropriate referrals were made for the family to receive extra support and to ensure the child was safe.

Consent to care and treatment

There was a practice policy for documenting consent to for specific interventions. There was a record of each patient's verbal consent documented in their electronic patient notes confirming discussion about relevant risks, benefits, and complications of proposed treatment. The practice completed an audit which included documentation of consent for minor surgery procedures. The audit showed that the practice achieved 54% rather than the 100% standard in this particular area. A template has been implemented in the clinical system to ensure that consent is recorded. The practice planned to carry out the audit again to ensure that improvements have been made.

Health promotion and prevention

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 87.1% which was higher than the CCG average of 83.4% and the national average of 74.3%.

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

- Under two year olds ranged from 84.9% to 98.1% which was comparable with the CCG average of 87.1% to 98.2%
- Five year olds from 95.5% to 100.00% which comparable to the CCG average of 92.2% to 100%.

Flu vaccination rates for the over 65s were 71.27%, and at risk groups 45.27%. These were below to national averages of 73.24% and 52.29%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice routinely invited patients by letter and information was available on the website and in the practice leaflet. Later appointments with nursing staff were available to accommodate the patients who were working.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed staff being polite and helpful to patients. Ten patients that we spoke with told us that they were treated with respect and dignity.

We received 49 comment cards, most of these were positive about the practice and the staff. Patients commented that the service was excellent; they told us the staff were efficient and welcoming.

On the day of the inspection we spoke with the chair of the patient reference group who was positive about the practice and staff, and told us they found the staff kind and caring. A manager of a local nursing home told us that the patients living in the home were happy with the service that the practice provided. The manager reported that a regular GP attended the home weekly, and during the ward round would speak with patients and their relatives. The manager reported the GP had displayed kindness and respect to patients, relatives, and staff.

The reception area was open and conversations could be overheard, the reception staff we spoke with knew when the patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. The practice played soft music in the waiting area to minimise the risk of conversations being overheard.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity, and respect. The practice performance was above the CCG and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 97% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 93% said the nurse was good at listening to them compared to the CCG average of 93% and national average of 91%.
- 95% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 90% said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.

- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and national average of 97%
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 97% and national average of 95%
- 94% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 91% patients said they found the receptionists at the practice helpful compared to the CCG average of 91% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

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

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 92% said that the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- 90% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 81%.
- 84% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

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

Are services caring?

Patient and carer support to cope emotionally with care and treatment

The practice provided an extensive range of leaflets and information in the waiting areas; this included information for carers and families. The practice employed a carers' champion, who had links with local support networks and was able to sign post carers to these agencies for extra support and information. The staff member we spoke with told us that she liaised with the local carer's federation and organised a drop in session. At this session carers were able to access practical advice for things such as benefit claims, respite care, and support. We saw that the carers' champion made up packs of appropriate leaflets about the local agencies and gave these to carers.

The practice system had recorded that 78 patients had a carer and that 78 were a carer. There was one young person recorded as a carer. The practice proactively asked about carers by asking every new patient that registered at the practice, with posters in the waiting areas, through the carer's federation representative and by health professionals identifying patients that cared for others.

Staff we spoke with told us that the GPs would support patients through their end of life and would continue to support the relatives. The GPs would contact the patient either by telephone or visiting and support the patient. We spoke to a relative who told us that this contact and support from the GP had been very helpful.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff at the practice worked hard to understand the needs of their patients. Both clinical and non-clinical staff demonstrated a clear understanding of the concept of personalised care for the patients according to their individual needs. For example:

- The practice looked after some of the patients living at a unit which was part of the local mental health hospital. The practice offered drop in appointments during lunchtime so that the patients from the unit could attend the surgery for routine or urgent appointments. This enabled and encouraged patients, who could otherwise be marginalised to engage with the wide range of healthcare services.
- The practice offered later appointments three evenings a week, on a Monday, Wednesday, and Thursday evening until 6.30pm for working patients who could not attend during normal opening hours.
- Telephone consultations were available for those patients who were seeking advice.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or those who could not or would not leave their home.
- Urgent access appointments were available for people with serious medical conditions.
- The practice as part of the Rushcliffe CCG worked with other local practices and provided appointments for patients on a Saturday or Sunday morning as part of the Prime Minister's Challenge Fund.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11.00am every morning; this was extended if there was a higher demand for appointments or staff shortages due to sickness. Afternoon appointments were available from 3.30 or 4.00pm to 6.00pm daily. The practice offered extended hours for pre booked appointments on Monday, Wednesday, and Thursday evening to 7.30pm.

In addition to pre-bookable appointments which could be booked up to four weeks in advance, urgent appointments were available for people who needed them. Appointments were available on line; this was advertised in the waiting areas and the practice booklet.

Continuity of care was a priority for the practice, the practice did not use locum GPs regularly, instead the GPs at the practice covered for each other in the event of leave.

We reviewed results from the national GP patient survey which showed that patients' satisfaction with how they could access care and treatment were above local and national averaged for most indicators. For example:

- 75% of patients were satisfied with the practice's opening hours this was comparable to the CCG average of 75% and national average of 75%.
- 90% patients said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.
- 87% patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 79% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.

People we spoke to on the day were able to get appointments when they needed them.

The practice engaged with the Rushcliffe Clinical Commissioning Group (CCG) to monitor and benchmark referral patterns and attendances at secondary care. The data produced by the CCG displayed in graphs, showed that the practice had the lowest number of first attendances at outpatients. The practice told us that they maximised the skills that were available in house and that they had a higher number of patients that had private insurance. The regular GPs within the practice oversaw the referrals made by the registrar GPs to ensure that they were appropriate.

The practice acknowledged that, within the Rushcliffe Clinical Commissioning Group (CCG) area they had previously the highest number of patients that attended the accident and emergency department (A+E) within the hours that the practice was open. The most recent data indicated performance had improved following steps the practice had taken.

Are services responsive to people's needs?

(for example, to feedback?)

When the practice is closed, Nottingham Emergency Medical Services (NEMS) provided urgent medical care for the patients.

Listening and learning from concerns and complaints

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

A patient who had made a verbal complaint told us they had not heard anything further from the practice. The practice manager told us that she would personally speak with patients who wished to complain or give feedback rather than asking the patient to put the complaint in writing. Staff confirmed verbal complaints were not recorded. This is not in line with the practice policy as the practice leaflet states that complaints can be made verbally or in writing.

The practice had recorded three complaints from 12 January 2015 to date of inspection. These complaints had been dealt with appropriately and within a timely manner and actions to improve had been highlighted.

Are services well-led?

Requires improvement 

(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 vision to deliver high quality care and promote good outcomes for patients. Details of the vision and practice values were part of the practice's strategy and five year business plan.

Governance arrangements

The overarching governance framework which supported the delivery of the strategy and good quality care had weaknesses and did not always ensure that the management team had a comprehensive understanding of the performance of the practice. The arrangements for identifying, recording, managing risks, issues, implementing mitigating actions and sharing learning was not robust. Staff were not always aware of their own roles and responsibilities.

The practice showed us that some significant events were recorded, investigated, changes made and learning shared. For example, the practice made a significant breach of identifiable patient information. We saw evidence that the patient was appropriately contacted, the practice procedures reviewed and new procedures embedded. The practice involved NHS England and the National Information Governance Team.

However, some practice staff told us that they did not log any significant events or near misses. For example, the staff we spoke to told us that any errors identified with dispensing medications would be discussed with the GP concerned but that they did not record any near misses or significant events.

Staff meetings were held each two months for the practice team, minutes were taken and were available to staff.

There was an electronic storage system where staff could access the information they needed whilst restricting certain confidential information to nominated staff. We looked at the policies and procedures, and we saw that staff had signed to say they had read these. This signature was stored in the staff personnel file. The staff we spoke to confirmed that they knew how to access this information.

Leadership, openness and transparency

The partners in the practice had the experience, capacity, and capability to run the practice and ensure high quality

care. They prioritised high quality and compassionate care but the weaknesses in the system did not ensure that they had sufficient oversight to assure themselves that all risks had been identified, assessed, and mitigated.

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Clinical meetings were held every month and a full practice team meeting every two months. Minutes from these meetings were taken and available to all staff. All the staff said they felt respected, valued and supported by the partners and managers in the practice.

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

The practice was actively engaged with the patient reference group (PRG). The chair from the PRG told us the practice had worked with the group and had improved services for patients.

The practice and the PRG met monthly, a GP and the practice manager attended the meeting with at least six of the 12 members of the group in attendance. The practice PRG also had 100 members who contributed virtually. Minutes from these meetings were held on the web site and on a notice board in the practice.

The practice and the PRG held a health event each year, each event focussed on a different health issue. We were told that over 40 patients and invited consultants as well as practice staff attended. The topics included respiratory health, looking after your back and looking after your heart. Patient feedback was very positive and the practice was continuing with this annual health promotion event.

The practice gathered feedback from patient surveys and from the family and friends test. Data from the GP Patient Survey July 2015 showed that 260 surveys were sent out and 111 responded this was 43% completion rate.

95% of patients described their overall experience of this surgery as good compared with the CCG average of 90% and the national average of 85%

87% of patients would recommend this surgery to someone new to the area compared with the CCG average of 83% and the national average of 78%.

Innovation

Are services well-led?

Requires improvement



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

We saw examples of the new initiatives where the partners were leaders in development of new services and of advanced technology. For example the practice, with the CCG, had engaged a fracture liaison nurse to develop a service within the Rushcliffe CCG area to improve the health

of the patients to increase the prevention of fractures in patients who were at higher risk. A local care home that the practice worked with told us about a pilot to introduce Skype consultations for patients living at their service.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users.</p> <p>Among the things which a registered person must do to comply with the regulation include:</p> <p>12(2)(g) the proper and safe management of medicines</p> <p>Staff responsible for the management and administration of medication must be suitably trained and competent and this should be kept under review. Staff must follow policies and procedures about managing medicines, including those related to infection control. These policies and procedures should be in line with current legislation and guidance and address:</p> <ul style="list-style-type: none">o Supply and orderingo Storage, dispensing and preparationo Administrationo Disposalo Recording <ul style="list-style-type: none">• We found that fridges were over filled and the system for checking and recording the temperature of the fridges in the dispensary and the treatment room was not sufficiently robust. Medicines stock levels were not robustly monitored and we observed that out of date medicines were available for use in the treatment room and on the emergency trolley. <p>12(2)(b) doing all that is reasonably practicable to mitigate any risks –</p>

Requirement notices

Providers must comply with relevant Patient Safety Alerts, recalls, and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS).

- The practice did not have a robust system to ensure that information received from safety alerts was managed, monitored and learning was shared.

Incidents that affect the health, safety, and welfare of people using services must be reported internally and to relevant external authorities/bodies. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result.

- The practice did not have a robust system that was would ensure that learning from significant events, near misses, and complaints was recorded, learning shared, and improvements made.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

(2) Persons employed by the service provider in the provision of a regulated activity must—

(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

There was a lack of understanding and consistent approach towards the storage and recording of Schedule 3 drugs.

- New staff in the dispensary did not have a robust training plan to ensure that learning, monitoring and assessing of competency was robust.