# Radford Medical Practice

## Quality Report

Student Health Centre
Nottingham Trent University
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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 Radford Medical Practice on 03 November 2014, as part of our new comprehensive inspection programme. The practice had not previously been inspected.

The provider has a total patient list size of 16,700; with 13,400 registered students at the practice we inspected and 3,300 patients registered at the other location.

Our key findings were as follows:

- Patients reported good access to the practice and continuity of care, with urgent appointments being made available on most occasions.
- The appointment system was flexible and enabled patients to access care and treatment outside university and working hours.
- The practice had appropriate systems in place to keep patients safe.
- The practice was caring and patients were treated with kindness and respect.
- An open culture and team based approach was promoted within the practice. Staff felt well supported with their professional development and enabled to carry out their work effectively.
- The practice staff were all committed to improving the quality of care and services provided for the student population.
- The practice was proactive in promoting health promotion, screening and prevention. This included:
- opportunistic “roadshows” in student halls of residence where sexual health, alcohol and drug use information and advice was provided;
- integrated work with Nottingham Trent University and Public Health in cases of health outbreaks:
- chlamydia treatment and then making referrals to a local health centre for contact tracing. Contact tracing involves finding and informing the contacts of a person with an infection so they can get information, testing and treatment.
- Information and advice on sexual health was provided in different formats and languages including French, Arabic and Chinese.

# Summary of findings

All these initiatives had made a positive impact on patient's awareness of health promotion and disease prevention.

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

**Action the provider should take to improve**

- The practice should ensure that a yearly infection control audit is completed.
- The practice should ensure clear signage for the self-monitoring BP machine is in place for students to easily access the service.
- The practice should ensure that all staff receive training updates in line with the provider's stipulated frequency so as to be assured that staff have up to date knowledge to perform their roles.
- The practice should ensure that changes made to processes and systems after significant event findings are reviewed to evaluate impact in quality improvement.
- The practice should ensure the recording of all clinical meetings where patient information and NICE guidelines are discussed to strengthen the evidence of case management work undertaken and peer support.

**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.

Information about safety was recorded, monitored, appropriately reviewed and addressed. This included the practice investigating incidents and significant events to ensure accountability. Lessons were learned and communicated to all practice staff to support improvement. There were suitable arrangements in place to safeguard patients at risk of abuse.

A variety of posters, leaflets and pocket sized cards signposting students and staff on how to report a safeguarding concern and domestic violence or abuse were displayed in the patient waiting area and toilets. Staff were aware of their responsibilities to share information, document safeguarding concerns and how to contact the relevant agencies.

The practice had systems in place to manage and review risks to students' health and general wellbeing. We found risks to patients were assessed and appropriately managed to keep students safe.

There were suitable arrangements in place to ensure the safe use of equipment and medicines management. There were sufficient numbers of staff with an appropriate skill mix to keep people safe. The practice should ensure that a yearly infection control audit is completed to protect patients, staff and others from the risk of infections.

### Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to National Institute for Health and Care Excellence (NICE) guidance to inform the care and treatment of patients. Patient needs were assessed and care was planned and delivered in line with best practice. Effective recall systems were in place to check that all routine health checks were completed for patients with long-term conditions and mental health needs patients.

The practice shared information appropriately and worked well with other agencies for the better care of patients. Multi-disciplinary working with other professionals was taking place and the practice had identified this as an area of development. The GPs used clinical audits to drive improvement in patient outcomes. Staff were supported with relevant training appropriate for their roles.

The practice's proactive approach to health promotion, screening and prevention was an area of good practice.

# Summary of findings

**Are services caring?**

Good

The practice is rated as good for providing caring services.

We spoke with six patients, received 48 completed comment cards, and reviewed the 2013/14 practice satisfaction results. The patient feedback from all three sources showed patients were treated with compassion, dignity and respect; and they were involved in decisions about their care and treatment.

We observed a patient-centred culture during our inspection, and saw that patients were treated well. We found positive examples to demonstrate how people's choices and preferences were valued and acted on, in particular the care for students with long term conditions and mental health needs.

Patients were signposted to support services to help them emotionally cope with their care and treatment when required. This included the university student support service, Eating Disorders in Students' Service (EDISS), voluntary organisations related to bereavement, drug and alcohol use. Home visits and bereavement follow-up appointments were also offered to ensure patients could access appropriate support.

The practice had a carer lead GP and the computer system alerted GPs if a patient was a carer. There was written information available for young carers to ensure they understood the various avenues of support available to them.

**Are services responsive to people's needs?**

Good

The practice is rated good for providing responsive services.

An area of good practice included the practice's proactive approach to health promotion, screening and prevention. This included:

- opportunistic "roadshows" in student halls of residence where sexual health, alcohol and drug use information and advice was provided;
- integrated work with Nottingham Trent University and Public Health in cases of health outbreaks:
- Chlamydia treatment and contact tracing in liaison with other sexual health centres. Contact tracing involves finding and informing the contacts of a person with an infection so they can get information, testing and treatment and.
- Information and advice on sexual health was provided in different formats and languages including French, Arabic and Chinese.

All these initiatives had made a positive impact on patient's awareness of health promotion and disease prevention.

# Summary of findings

Patients told us it was easy to get an appointment with a named GP or a GP of choice. This provided continuity of care. The practice offered appointments outside of university and work timetables. Improvements had been to the appointment system and accessibility of online services in response to patient feedback. A triage system was also in place to ensure patients needing urgent care were provided with urgent appointments and / or advice when need.

We found the practice offered a personalised tailored service for its student population and engaged with the NHS England Area Team and Nottingham City clinical commissioning group (CCG) to secure improvements to services where these were identified as being needed. The practice had been awarded a responsiveness contract by the CCG to improve the delivery of services, and ensure patients were at the heart of how services were designed and provided.

The practice was accessible to people with physical disabilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. The practice responded appropriately to complaints raised and we saw evidence of staff learning from complaints.

**Are services well-led?**

Good

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

The practice had a clear vision of ensuring high quality services for its student population. The practice was also committed to research and service improvement related to student health needs. Staff we spoke with demonstrated awareness of this vision and were clear about their responsibilities in relation to this. There was a clear leadership structure in place and staff felt valued by the management.

The practice had policies and procedures in place to govern various activities performed within the practice. These policies were regularly reviewed to take account of current models of best practice. There were appropriate systems in place to assess and monitor the quality of service provision and identified risks.

The practice proactively sought patient feedback which it acted on. The practice had a virtual patient participation group (PPG) as the students preferred communication via email. Staff had received inductions, regular performance reviews and attended staff meetings and events. Governance and performance management arrangements had been reviewed; with the practice working towards improving the structure of its multi-disciplinary working and clinical meetings.

# 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

**Not sufficient evidence to rate**

A rating is not applied for older people as the practice did not have registered patients over the age of 75.

At the time of our inspection, Radford Medical Practice provided care and treatment to the student population attending Nottingham Trent University; and 95% of the students were below the age of 25.

### People with long term conditions

**Good**

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

Most of the patients we spoke with were complimentary of the care they had received and felt their health care needs were being managed safely. They confirmed they were able to access appointments when needed and to see the same doctor for their condition, which was important for continuity of care.

The practice had identified asthma, diabetes, epilepsy, hyperthyroidism and rheumatoid arthritis as the main long term conditions the student population experienced; and there was a lead clinician for each condition. The GPs participated in clinical audit work and referred to the National Institute for Health and Clinical Excellence (NICE) guidelines to improve patient care. GPs and nurses carried out regular reviews to check that patient's health and medication needs were being met.

Some of the staff we spoke with acknowledged the challenges in meeting the care needs of some students as they did not always attend their GP or nurse appointments. As a result of this, the practice was proactive in engaging patients in the management of their own care; and follow-up letters or phone calls were made where patients had missed their appointments. We found the recall systems to be robust and effective in monitoring patient reviews and attendance.

For patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. This included support from the community diabetic nurse specialist and comprehensive care planning for all patients with diabetes.

The practice also offered enhanced services for warfarin anti-coagulation monitoring, patient testing for dermatology, gastroenterology, rheumatology and respiratory medicine. The

# Summary of findings

practice had emergency processes in place to ensure appropriate referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed.

**Families, children and young people**

**Not sufficient evidence to rate**

A rating is not applied as the practice did not have registered families, children and young people.

At the time of our inspection, Radford Medical Practice provided care and treatment to the student population attending Nottingham Trent University and all the students were above the age of 17.

**Working age people (including those recently retired and students)**

**Good**

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

The practice had identified the needs of the student population and adjusted the services it offered to ensure they were accessible and flexible. This included: appointments being available outside of university timetables (early morning, lunchtime and evening); GP telephone consultations; and on line services for requesting repeat prescriptions and booking appointments. Most of the students we spoke with were happy with these services and appreciated the convenience of the practice being located on campus.

We found some very good aspects of practice in relation to the practice's proactive approach to health promotion, screening and prevention. This included: opportunistic "roadshows" in student halls of residence where sexual health, alcohol and drug use information and advice was provided; integrated work with Nottingham Trent University and Public Health in cases of health outbreaks; and chlamydia treatment and contact tracing in liaison with other sexual health centres. Contact tracing involves finding and informing the contacts of a person with an infection so they can get information, testing and treatment.

Information and advice on sexual health was provided in different formats and languages including French, Arabic and Chinese. All these initiatives had made a positive impact on patient's awareness of health promotion and disease prevention.

We found other tailored services for the student population included: a weekly sexual health drop in service, a contraceptive service, weight management reviews, smoking advice, travel health

and immunisation. The practice was also registered as a yellow fever centre. Most students we spoke with were aware that a chaperone policy was in place and they could request for a chaperone when having intimate examinations.

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. Patients could also refer themselves for physiotherapy, chiropody and talking therapy services.

Students were able to easily register with the practice and were encouraged to do so before starting university in September. For example, an information pack was sent to the home address of all new students who had expressed an interest in registering with a local doctor. This initiative was to ensure that students were fully registered by the time they arrived in Nottingham.

**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's vulnerable patients included: students at risk of abuse; international students; and students with mild learning difficulties, dyslexia, autism and / or attention deficit hyperactivity disorder (ADHD). The practice worked in liaison with Nottingham Trent University staff, police and multi-disciplinary agencies to support more vulnerable patients. Medicines and health reviews were offered to patients, and where needed students were supported to complete health related forms.

The practice had suitable systems in place to provide patients with safeguarding information and to respond to cases of potential abuse. Leaflets about support groups related to domestic violence, alcohol and drug misuse were also available in the practice for patients to access. Staff had received training in safeguarding of vulnerable adults and were aware of their responsibilities regarding information sharing and documenting safeguarding concerns.

The practice had effective systems in place to ensure international students were supported in understanding the UK health system. This included joint working arrangements with Nottingham Trent University international office and student support services. For example, international students were provided with leaflets covering areas such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services.

The practice had access to interpreting and translation services for patients who do not speak English as a first language; and longer

appointments were offered. Students were prompted to choose a language of their choice when using the self-check in machine to confirm arrival for their appointment. One international student we spoke with gave positive feedback about the support they had received to register with the practice, as well as the care and treatment provided.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated good for the care of people experiencing poor mental health. There were no registered patients with a diagnosis of dementia at the time of our inspection.

The practice maintained a register of patients with mental health needs and depression. These patients received an annual health check to ensure their health needs were being met. Suitable re-call systems were in place to monitor patient attendance for their appointments, and where required follow-up action was taken. Patients were signposted to various support groups, university counselling services and psychological / talking therapies. GPs also provided reports for disability allowance entitlement for the students.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff were flexible in meeting patient's requests for appointment times; and longer appointments and home visits were offered when needed.

The practice had identified the need to improve the case management of students experiencing poor mental health so as to ensure a coordinated approach to their care and treatment. As a result, multi-disciplinary meetings with counsellors, the university student support service and a professor in psychiatry had been planned for 11 November 2014. These meetings were previously held once a term.

Staff were also due to attend mental health first aid training in November 2014. GPs we spoke with demonstrated awareness of working within the principles of the Mental Health Act (1983/2007) and Mental Capacity Act to ensure patients received safe and effective care.

The practice is currently involved in a project looking at young people that are at risk of self-harm. As part of the project the practice is working towards developing self-help literature. While

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|---|---|
| this was a good and innovative initiative, we could not evaluate the impact on patient care as the project had not been completed. Patients could still access information on self-harm from the practice website. | |

# Summary of findings

## What people who use the service say

The 2013/14 practice patient survey showed most of the 365 respondents were satisfied with the services offered by the practice. For example, the key results were: 83% of students described their experience of accessing the surgery as very good; 86% had confidence and trust in the GP or nurse they saw; 95.2% stated the GP was good at treating them with care and concern and 80% said GPs and nurses were good at giving them enough time to discuss their care needs.

91.1% stated the GP was very good at involving them in decisions about their care and 87% described the overall experience of their GP surgery as good. All these percentages were above the national practice average. 74% of students rated nurses as good at explaining tests and treatments; and 72% said they were involved in decisions about their care.

All of the six patients we spoke with were complimentary about the services they received at the practice. They told us: staff were very helpful and friendly; they were involved in decisions about their care; appropriate referrals to specialist services were timely; and the appointment system was easy to access. They also told us they were listened to and treated with respect and dignity at all times.

We reviewed 48 CQC comment cards completed by patients. Most of the comments were positive about the quality of services and care provided. The comments also reflected that patients were happy with the appointments system and found the premises to be clean and tidy. Seven out of the 48 comments stated improvements were still required to increase accessibility of appointments in the morning, reduce waiting times, and to improve staff knowledge.

We saw that in liaison with the Patient Participation Group (PPG) changes had been made to the telephone and online appointment booking system to improve access for patients. A PPG is group of patients who engage with practice staff to identify priorities for patients, and contribute to proposals for any service improvements.

## Areas for improvement

**Action the service SHOULD take to improve**

The practice should ensure that a yearly infection control audit is completed.

The practice should ensure clear signage for the self-monitoring BP machine is in place for students to easily access the service.

The practice should ensure that all staff receive training updates in line with the provider's stipulated frequency so as to be assured that staff have up to date knowledge to perform their roles.

The practice should ensure that changes made to processes and systems after significant event findings are reviewed to evaluate impact in quality improvement.

The practice should ensure the recording of all clinical meetings where patient information and NICE guidelines are discussed to strengthen the evidence of case management work undertaken and peer support.

# Radford Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to Radford Medical Practice

Radford Medical Centre (also known as the student health centre) provides primary medical services to a total of 13,395 students attending Nottingham Trent University. We inspected the practice during the first term and about 3,500 new patients had registered during this period. We found 95% of the registered patients were under the age of 25; and comprised of international and home students. The highest percentage of international students speak French and Mandarin Chinese.

Radford Medical Centre holds a Personal Medical Services (PMS) contract which has been agreed with NHS England. Some of the agreed services include: minor surgery, alcohol advice, as well as sexual health and chlamydia screening. The practice also offers travel vaccinations and care for patients with asthma and diabetes.

The practice is managed by Radford Medical Practice – Kaur, which also manages Radford Health Centre, in Ilkeston Road. We did not inspect Radford Health Centre as it is registered in its own right as a separate location. We found most staff worked at both the student and Radford health centres.

The practice employs four GP partners and two part time salaried GPs. Three of the GPs are female and three are male. The nursing staff comprises of one full-time nurse, two part-time nurses and one part-time healthcare assistant. The administrative staff includes a practice manager, assistant manager, seven receptionists and two temporary staff assisting with the student registration process.

Radford Medical Centre is involved in the training of medical students. The practice has opted out of providing out-of-hours service to their patients; and this service is provided by Nottingham Emergency Medical Services (NEMS). The practice offers reduced surgery sessions during university holidays and patients can always access the Radford surgery out of term time.

## Why we carried out this inspection

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

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

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.

# Detailed findings

## 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. These groups are:

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included information shared by the Nottingham City Clinical Commissioning Group and Local Area Team. We carried out an announced visit on 03 November 2014. During our visit we spoke with a range of staff (GPs, nurse, healthcare assistant, administrative staff, and Nottingham Trent University staff including the student health development officer).

We spoke with six patients who used the service. We observed how students were being cared for, reviewed patient records and care plans to corroborate our findings. We reviewed 48 comment cards which we left for patients to complete to share their views and experiences of the service.

Good

# Are services safe?

## Our findings

### Safe track record

We looked at a range of information available about the practice as part of our inspection planning. This included information from the General Practice High Level Indicators (GPHLI) tool, the General Practice Outcome Standards (GPOS) and the Quality Outcomes Framework (QOF). The latest information available to us indicated there were no areas of concern in relation to patient safety. We spoke with six patients on the day of our inspection and no concerns about patient safety were raised.

We found the practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We reviewed incident reports and minutes of meetings where incidents were discussed over the last 12 months. This showed the practice had taken appropriate action where needed and could evidence a safe track record over time. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed eight significant events that had occurred within the last 12 months. We found they had been recorded appropriately, investigations were undertaken and the findings were shared with all staff to minimise the events reoccurring.

Meeting minutes reviewed showed evidence of each significant event being discussed at practice learning and training events (PLT), learning points being identified and changes to systems agreed where needed. For example, all A&E reports detailing incidents of self-harm were passed to the practice nurses to enable them to make contact with the patient and arrange a GP appointment. The provider also sent emails to staff regarding the investigation findings of each significant event. However, there was no audit trail of checking that all staff had read the email especially those who had not attended the PLT.

Staff we spoke with told us they were encouraged to report any concerns or significant events and these were a standing item on the practice meeting agenda. We saw evidence of changes to the administration processes resulting from significant events linked to the processing of patient information such as referrals and MRI results. Where patients had been affected by something that had gone wrong, they were given an apology or provided with a written response and informed of the corrective actions taken. Staff understood their responsibilities to raise concerns, and to report incidents and near misses.

A system was in place for receiving and acting on national patient safety alerts. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure staff were aware of any that were relevant to the practice and where they needed to take action.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to students' health and general wellbeing. This included GPs using the required codes on their electronic case management system to ensure risks to students were clearly flagged and reviewed. This was also important to ensure other clinical staff were aware of any relevant issues when patients attended appointments.

We found risks to patients were assessed and appropriately managed. Health reviews were undertaken at least yearly and when required to ensure the safety of patients with mental health needs. In addition, recall systems were in place to review repeat medications for patients with multiple health needs and medicines, as well as students who persistently failed to attend appointments for health reviews.

The practice had safeguarding policies in place and these were available to all staff for guidance including contact details for raising concerns with the local safeguarding children and vulnerable adults' teams. A variety of posters, leaflets and pocket sized cards signposting students on how to report a safeguarding concern and domestic violence / abuse were displayed in the patient waiting area and toilets.

The practice had a lead GP for safeguarding vulnerable adults and children, and they had the coordinating role between the practice and other relevant agencies. For example multi-agency risk assessment conference (MARAC) meeting minutes and / or confidential information was shared with the police and Nottingham Trent University.

Good

# Are services safe?

MARAC is part of a coordinated community response to domestic abuse and professionals involved share information to increase the safety, health and well-being of victims/survivors - adults and their children.

The lead GP could demonstrate they had the necessary training to enable them to fulfil this role. They attended quarterly adult safeguarding meetings with other GPs and domestic abuse response team (DART) meetings. Staff we spoke with were aware of the lead GP and told us they could speak with them and / or their manager for advice if they had a safeguarding concern.

All staff had received training on safeguarding children; and most staff had received training on safeguarding vulnerable adults and domestic abuse. Staff we spoke with were able to describe different types of abuse and they told us what actions they would take if they had any concerns regarding a child or vulnerable adult. Staff we spoke with were able to demonstrate awareness of their duty of care to safeguard students from abuse and had received training relevant to fulfil their role.

In addition, some nurses and administration staff required a refresher course as their three yearly training had expired in July 2014. This was discussed with the provider and we were told further training had been planned for staff; and we will follow-up on this to confirm attendance.

There was a chaperone policy in place, which was visible on the waiting room noticeboard and in consulting rooms. All nursing and administrative staff acting as chaperones had received training and understood their responsibilities. This included where to stand to be able to observe the examination. Staff also had access to panic buttons in clinical rooms and the reception area should a need arise to raise any safety concerns

## Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were kept safely. For example, medicines were stored securely in lockable cupboards and were only accessible to authorised staff. The temperatures of storage areas were checked and recorded daily to ensure medicines were stored at an appropriate temperature in line with manufacturers' guidelines.

Processes were in place to check medicines including vaccination stock were within their expiry date and suitable for use. All the medicines we checked including emergency medicines kept in two GP bags were within their expiry dates and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

Students we spoke with told us their repeat prescriptions were often ready for collection within 24 to 48 hours, and using the online system made getting repeat prescription quicker. We found the practice had appropriate systems in place for the prescribing and repeat prescribing of medicines. For example, only a GP could prescribe new medicines and all requests for repeat medicines had to be made in person or via email.

The practice policy for prescribing antibiotics was in line with the National Institute for Health and Care Excellence (NICE) guidelines and the practice had a prescribing lead GP. Staff we spoke with and records we looked at showed prescriptions were reviewed and signed by a GP before they were given to a patient. We found blank prescription forms were kept in a locked room and GPs kept some prescription pads in their bags. Although the doctor bags were not always locked away, GPs we spoke with told us they were kept securely with them at all times.

Records reviewed showed staff completed clinical audits relating to the prescribing of specific medicines such as minocycline (used to treat bacterial infections and skin infections) and quinolone (antibiotic for malaria treatment). This allowed the practice staff to check that GP's prescribing practice was in line with local and national guidelines. The outcome of the clinical audits were discussed amongst the GPs to support improvement in medicines management.

Records reviewed showed the Clinical Commissioning Group (CCG) pharmacist carried out prescribing audits on a regular basis and the GPs attended an annual prescribing meeting. The CCG medicines management team also undertook audits. We saw records of actions taken in response to a review of prescribing data.

There was a monitoring system in place for the management of high risk medicines, and appropriate action was taken based on the results. A robust recall system was also in place to ensure that patients attend their medicine reviews on time. This included alert messages popping up when a patient's medicines were due for review or required monitoring.

Good

# Are services safe?

We found nurses administered vaccines using Patient Group Directives and Patient Specific Directives that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. Non-clinical staff had also received prescribing training relevant to their roles.

## Cleanliness and infection control

All the patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. This was also reflected in all 48 comment cards we received. We found the premises to be visibly clean and tidy during our inspection. Records reviewed showed the university maintenance department carried out all the cleaning and legionella testing to reduce the risk of infection to staff and patients. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand gel and hand towel dispensers were available in treatment rooms and toilets.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. This included single use of equipment for specific procedures. The practice had policies on infection control, minimising blood borne virus transmission, decontamination, cleaning, hand hygiene and use of personal protective equipment. There were suitable arrangements for the segregation and regular disposal of waste via an approved contractor.

The practice had a lead member of staff for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received two yearly updates. We noted some staff were due refresher training in November 2014 and this was highlighted to practice management to address. We were advised further refresher training would be provided although a date was yet to be confirmed at the time of our inspection.

Records reviewed showed the most recent infection control audit and been completed January 2013 and the action plan had been reaudited in May 2013. The plan showed improvements to identified concerns were completed on time; with the practice achieving 97% compared to the initial 78%. The practice should ensure that a yearly infection control audit is completed in line with best practice and to minimise risks to patients, staff and others.

## Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly, and we saw records that confirmed this. The university was responsible for maintaining and repairing equipment within the practice to ensure that patients and staff used safe equipment. For example,

all portable electrical equipment was routinely tested and stickers were displayed indicating the testing dates and date for validity. Staff we spoke with were aware of the reporting procedures and told us the university responded promptly to their requests. This was also confirmed by one of the university staff we spoke with and a schedule of testing was in place. We saw evidence of calibration of equipment such as weighing scales and the fridge thermometer.

## Staffing and recruitment

The provider had a recruitment policy in place which set out the standards it followed when recruiting clinical and non-clinical staff. Records reviewed showed appropriate recruitment checks had been undertaken before staff began work. For example, proof of identification, employment references, qualifications, immunisation records and criminal records checks through the Disclosure and Barring Service (DBS). Professional registrations for individual staff nurses and GPs were in date and were also checked to ensure they were allowed to work by the Nursing and Midwifery Council and the General Medical Council.

All new staff received an induction that was relevant to their role at the start of their employment. These checks and the induction assured the provider that staff were of good character and were competent to carry out their role and meet patient's care needs. The management felt the practice staff were loyal and an experienced team with a good skill mix.

Good

# Are services safe?

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

We found two additional staff members had been recruited to support with the student registrations at the beginning of the university term due to increased registrations of approximately 3,500 patients. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave

## Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and relevant information was displayed for staff and patients to see. Staff had received health and safety training as well as fire safety. The practice had planned for a health and safety audit for December 2014 with an external company.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: there were emergency processes in place for patients with long-term conditions and staff gave us examples of referrals made for patients whose health deteriorated suddenly. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice also monitored repeat prescribing for patients receiving medication for mental ill-health.

The practice offered a triage system whereby urgent requests for an appointment were triaged by the practice nurse. The nurse would make an initial assessment over the phone and book an appropriate appointment, give advice or signpost the patient to the most relevant service.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to deal with unforeseeable emergencies. This included a business continuity plan to deal with a range of emergencies and risks that may impact on the daily management of the practice. Identified risks included loss of paper records, electronic system / hardware failure, staff absences and fire. Mitigating actions had been put in place to reduce and manage the risk. The plan also contained relevant contact details for staff to refer to.

Staff we spoke with were aware of actions they should take in the event of a medical emergency and / or fire to ensure people's safety was maintained. This included calling the emergency services and implementing the provider's procedures for fire evacuation. Records reviewed showed all staff had received training in basic life support; and most staff had also received training in medical equipment and emergency drugs. Records showed most staff were up to date with fire warden and fire safety training; although some staff required refresher training in fire safety in line with the provider's requirement for yearly training update.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We checked the GPs' bags and found emergency drugs were in date and inside the bag was a protocol for cardiac alert and data sheet with the expiry dates of emergency drugs.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. This included guidelines from the National Institute for Health and Care Excellence (NICE) and Nottingham City clinical commissioning group (CCG). The practice had identified a need to increase multidisciplinary working and improve on documenting practice meeting discussions where: new guidelines were disseminated, the implications for the practice's performance and the required actions were agreed. This would ensure that all staff were up to date with best practice guidance and identify areas for clinical audit.

Our discussions with the GPs and nurses, as well as a review of records, showed staff completed assessments of patients' needs and these were reviewed when appropriate. We looked at three patient care plans to corroborate the information staff had told us.

The GPs told us they lead in specialist clinical areas such as diabetes, rheumatoid arthritis and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions relevant to the patients. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. This supported staff to continually review and discuss new best practice guidelines for the management of patients' health needs.

Diabetic care plans we looked at showed the patient's health needs had been assessed, and an action plan agreed to minimise any identified risks. We found the practice had achieved positive results for the diabetic care of patients. This included involvement of the community diabetic nurse, clinical audit work and targeted reviews of patients' health needs and medicines. For example, in 2013/14 the practice made improvements around lowering blood pressure of diabetic and hypertensive students.

This was achieved by the following initiatives: a list of all chronic patients with blood pressures above the recommended National Institute for Health and Care Excellence (NICE) clinical guidelines was produced and contact was made with them to discuss their blood pressure readings. This was evidenced in the records that we looked at. We looked at three patient care plans to corroborate the information staff had told us. Patients were then reviewed and had their blood pressure checked following any medication changes.

In addition, a clinical audit in February 2014 related to the control of glycaemic control for Type I diabetic students showed the average HbA1C (HbA1c refers to glycated haemoglobin which identifies average plasma glucose concentration) had reduced from 75.05 to 60.59 compared with the previous year. For patients with diabetes this is important as the higher the HbA1c, the greater the risk of developing diabetes-related complications. The audit had been through three complete cycles.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling patient reviews, and managing safeguarding information and medicines management. Staff were able to demonstrate how care was planned to meet identified needs using best practice templates and how patients were reviewed at required intervals to ensure their treatment remained effective.

The practice maintained registers for patients with long term conditions such as asthma, hypothyroidism and epilepsy, as well as severe mental health and depression. These registers were used to arrange annual and / or regular health reviews to check patients' health and the effectiveness of medicines. Medication reviews were also completed opportunistically by GPs when patients attended the practice or when repeat prescriptions required re-authorisation. We found the practice had robust recall systems to ensure patients attended their health reviews. Two patients we spoke with told us they had been referred to other specialist services in hospital for further treatment.

The practice had a system in place for completing clinical audit cycles. The GPs we spoke with were aware of and could describe audit activity across the practice. The practice showed us seven completed clinical audits that

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# Are services effective?

## (for example, treatment is effective)

had been undertaken within the last 12 months. One of these audits showed a completed cycle and the practice was able to demonstrate the changes resulting since the initial audit. This related to auditing of glycaemic control of Type I diabetics as previously discussed in this report.

Another completed audit included a review of all HIV patient records to identify whether pneumococcal vaccination had been given in line with Nottingham guidelines. The practice also undertook an audit of satisfaction questionnaires for patients who had received subdermal implants in October 2013. Each questionnaire was analysed and of the 15 received all felt that the procedure and aftercare was clearly explained; and they were satisfied with the care they had received.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

The GPs told us clinical audits were often linked to medicines management information, patient health needs, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is an annual reward and incentive programme detailing GP practice achievement results. For example, we saw an audit regarding quinolone (antibodies to treat a variety of bacterial infections) prescribing to check that prescribing was in line with local guidelines. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and local benchmarking to monitor patient outcomes. Benchmarking is a process of evaluating performance data for the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example flu and pneumococcal vaccination uptake was 77.4% and higher than the CCG average of 72.6%. However, some of the QOF data was combined with another location owned by the provider. Therefore, in some cases the demographics of the student population impacted on the QOF results.

### Effective staffing

The practice staff comprised medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with the provider's mandatory courses such as annual basic life support, infection control and hygiene. All staff including GPs undertook annual appraisals that identified learning needs from which action plans were documented.

Staff we spoke with confirmed the practice was proactive in providing practice based training and staff were encouraged to attend learning events, conferences and CCG based training. Training records showed most staff had attended the practice's mandatory training, and some staff were overdue their refresher training in line with the provider's update requirements. This was discussed with the management and we were provided with assurance that future courses had been planned.

One staff member we spoke with told us they were supported to undertake a National Vocational Qualification within 12 months of their employment. Staff told us they felt confident in performing their roles and responsibilities, and were encouraged to ask for help and support. They gave examples of when they had asked, for instance, a GP or nurse for additional clinical support if they needed advice.

The practice had an induction process in place for all new staff including GPs and locums. This ensured that staff were properly trained, supervised and appraised. Staff were also multi-skilled in some areas and could cover staff absences when needed. This was also in line with the provider's study and training policy.

We noted a good skill mix among the doctors, with each one of them having additional diplomas and / or specific clinical interest related to the student population health needs. For example, sexual and reproductive medicine and dermatology. The GPs were registered with the General Medical Council (GMC) and had been revalidated or had a date for revalidation for 2015/6. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil

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# Are services effective?

## (for example, treatment is effective)

these duties. For example, on administration of vaccines, cervical cytology (cervical screening test previously known as a smear test) and sexual health. Those with extended roles, for example seeing patients with long-term conditions such as asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

The practice nurses were supported by a member of the administrative team who was also trained as a healthcare assistant. Nursing staff held regular clinical supervision and discussion meetings, and continuing professional development for nurses was monitored as part of the appraisals process.

### Working with colleagues and other services

The practice worked with other service providers where responsibility for the care and treatment of patients was shared; in particular management of complex cases. Cooperating with other providers included effective communication and information sharing about patients health needs between the practice and other services. For example, blood results, discharge letters and information from out of hour's providers were mainly received electronically.

Patient information was also received via post and scanned into the patient's record. All this information was shared with the relevant GP each morning for action. The GPs recorded their actions around results, and arranged to see the patient if a follow-up was required.

There was a system in place to ensure scanned documents were not sent to a GP who was on leave, and results were redistributed among the GPs. Both administrative and clinical staff we spoke with were aware of their responsibilities in passing on, reading and acting on patient information on the day they were received. The practice had also identified where results had not been followed up appropriately and these were investigated as a significant event. The findings were then discussed with staff to promote learning.

The practice was commissioned for the new enhanced service to follow up patients discharged from hospital following self harm. This requires an enhanced level of service provision above what is normally required under the core GP contract. We saw that hospital communications were being acted upon. For example, all A&E reports were reviewed by the GPs and any felt to be inappropriate were forwarded to the practice nurse to discuss alternatives to attending A&E.

Leaflets and posters about attending A&E and using services appropriately were also available to patients. The "choose the right services get the right care" phone application was also promoted. This included information on pharmacies, NHS 111 and walk in centres.

The practice held multidisciplinary team meetings each academic term to discuss the needs of complex patients, for example those with long term conditions. These meetings were attended by a diabetic community nurse, university student development worker and other health care professionals. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and had identified this as area of improvement to ensure the effective coordination of students with poor mental health. The practice also participated in meetings each academic term attended by staff from the university student support service, EDISS and counselling services all located on campus.

The practice was part of a clinical commissioning group (CCG) local network of GP practices located in Nottingham inner city. The practice participated in a peer review system to share learning and improve patient care. We reviewed CCG reports and found GPs reviewed comparable data amongst practices, benchmarked outcomes and conducted peer reviews. The practice manager told us they met regularly with other practice managers and they felt this had been beneficial for themselves, the practice and their patients.

### Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS web) to coordinate, document and manage patients' care. The use of Emis web software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference and all staff were fully trained on using the system.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice referred patients to other specialist

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# Are services effective?

(for example, treatment is effective)

services through the Choose and Book service. This system enabled patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital. In case of medical emergencies, there were forms on patient records detailing their end of life decisions and these could be shared with the ambulance crew and hospital when needed.

The university student health development officer told us the student support service had positive working relationships with the practice; and staff were sharing patient information with the patient's consent, to ensure students received appropriate care and support. Information sharing was both formalised and informal. For example referrals were made for counselling services and telephone discussions were held. We were told health monitoring of patients were also discussed at meetings each academic term to review treatment strategies and identify any required actions or changes.

### Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it; however not all staff had received formal training. All clinical staff we spoke with understood the key parts of the legislation and were able to describe how this was implemented in their practice. This included a clear understanding of Gillick competencies. (These competencies help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice had a Mental Capacity Act policy in place to help staff support patients and their next of kin, with best interest decisions where mental capacity was an issue for the patient. Patients with long term conditions were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if there were changes to their health needs.

There was a policy for documenting consent for specific interventions. For example, patients were required to sign a consent form for all minor surgical procedures, insertion and removal of implanon, depot provera (an injectable birth control method) and referrals for counselling. The completed forms were then scanned and stored in the patient's electronic notes. The consent forms showed risks of the specific procedure had been discussed with the patient which enabled them to make an informed decision to consent to the treatment. Staff had an understanding of expressed and implied consent when providing treatment and care during their consultations.

### Health promotion and prevention

An area of good practice included the practice's proactive approach to health promotion, screening and prevention. This included:

- opportunistic "roadshows" in student halls of residence where sexual health, alcohol and drug use information and advice was provided;
- integrated work with Nottingham Trent University and Public Health in cases of health outbreaks:
- chlamydia treatment and contact tracing in liaison with other sexual health centres. Contact tracing involves finding and informing the contacts of a person with an infection so they can get information, testing and treatment and.
- Information and advice on sexual health was provided in different formats and languages including French, Arabic and Chinese.

All these initiatives had made a positive impact on patient's awareness of health promotion and disease prevention.

We received positive feedback from another staff member at the Nottingham Trent University student health centre. They commented that the partnership working with the practice staff on the Healthy Halls Roadshow had particularly been appreciated and they were very happy with the response they received from GPs in relation to specific student cases.

Practice staff attended the university registration weekend and were allocated an area and cubicles for nursing staff to provide health promotional advice – sexual health, alcohol advice and c-cards. The c-card scheme is a service for young people (aged between 13 and 24) to get free condoms, lubricants and advice about sex and relationships.

The practice health care assistant and nurses were also involved in other health promotion initiatives together with the university student health centre. We saw that chlamydia packs and related information were also available in patient toilets. This included pocket sized cards on a range of sexually transmitted infections (STIs) and how to access advice and treatment.

Good

# Are services effective?

## (for example, treatment is effective)

The practice nurses managed a weekly drop in service for sexual health needs on a Wednesday morning, and a weekly contraceptive implant service was also led by the GPs. New students received information packs with health promotion leaflets to promote their awareness.

We found the practice offered advice and vaccinations as part of their travel health service and were a registered yellow fever vaccination centre. Leaflets on health promotion were also available in other languages including a Chinese simplified translation of teenage immunisations. The practice had robust systems in place to follow-up on patents who failed to attend vaccination and screening programmes.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, audit work into healthy weight / disordered eating in young adults (18-25) enabled the staff to give appropriate advice on weight management and refer onto specialist services. For example, staff referred patients to the Eating Disorders In Students Service (EDISS) which was provided on campus. EDISS provided drop in (no appointment needed) clinics where students (or concerned others) will be able to gain health information, advice and guidance regarding eating disorders from experienced nurse specialists.

Records reviewed showed the practice had made improvements to the recording of smoking data in patient records and offering smoking cessation advice. This had largely been achieved by the practice nurses and health care assistant offering targeted smoking cessation during the university student registration week.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

Most of the patients we spoke with told us the practice offered a good service and they were satisfied with the care they had received. Patients described staff as being friendly, approachable and polite. Some patients emphasised that practice staff were sensitive and had a positive attitude when providing information and care related to sexual health and this made them feel at ease.

This positive feedback was also reflected in the comment cards we received. For example, 41 out of 48 cards had positive comments about the service experienced. Patients overall view of the practice included the following key themes: staff were described as having a genuine concern for student health and were commonly referred to as kind, understanding and caring; staff listened to student's individual concerns on most occasions; and their care needs were responded to in a timely manner.

Seven out of 48 completed CQC comment cards were less positive and key areas related to the appointment system, waiting times in the reception area, and staff knowledge. We saw that changes to the telephone and the appointment system were regularly reviewed and changes made to improve access for patients.

We observed staff treating patients with dignity and respect, and this was confirmed by all patients we spoke with. Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room with the doors closed. Curtains were provided in consulting and treatment rooms to ensure patients' privacy and dignity was maintained during examinations, investigations and treatments.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patient information. However, the practice may wish to note that a few patients told us they were conscious they could be overheard in the waiting / reception area and were not always advised that a room could be made available to discuss their personal information.

We also reviewed the most recent information available for the practice on patient satisfaction. This included the 2013/14 practice's patient survey and national patient survey results. Records reviewed showed 375 students had responded to the practice survey results and the feedback was mostly positive. For example, 94% of respondents stated the receptionists were helpful and 78% said they were treated with care and concern.

The 2013/14 national patient survey results we held were an amalgamation of the data for this practice and another location (Radford Medical Centre - Kaur) operated by the same provider. We did not inspect Radford Medical Centre – Kaur as it is registered as a separate location by the Care Quality Commission.

Although the results were not specific to the student health centre practice, we noted the patient respondents' feedback was positive; and we saw that most practice staff worked at both locations. For example, 95.2% stated the GP was good at treating them with care and concern, 91.1% stated the GP was very good at involving them in decision about their care and 87% described the overall experience of their GP surgery as good. All these percentages were above the national practice average.

### Care planning and involvement in decisions about care and treatment

Most patients we spoke with told us their health needs were discussed with them and they felt sufficiently involved in decision making about the care and treatment they had received. They also told us they felt listened to and supported by staff; and had sufficient time during consultations to make an informed decision about the choice of treatment they received. Patient feedback on the comment cards we received was mostly positive and supported these views.

The 2013/14 practice patient survey results showed GPs and nurses were good at: giving the patients enough time to discuss their care needs; listening to them; explaining tests and treatments; and involving patients in decisions about their care. The percentages achieved for each of the above areas were 80%, 81%, 74% and 72% respectively. However, approximately 8% of respondents did not rate / answer questions related to the above.

We looked at three patient care plans to corroborate what we had been told by staff. The care plans we reviewed showed evidence of each patients needs being assessed, individual preferences were considered, involvement in agreeing these, and risk assessments completed where required. This included care plans for patients with

diabetes and mental health needs. The practice was a member of the family doctor association which is part of a national network of GP practices that believe in the importance of continuity of care and offer a "My GP" option.

Staff told us interpreting services were available for students whose first language was not English to ensure they could be fully involved in discussions about their care. This also included written literature on a range of conditions that had been translated in other languages such as Chinese and French. We noted this information was displayed in the practice reception/waiting area and hallway for students to access.

### Patient/carer support to cope emotionally with care and treatment

Patients we spoke with and the comment cards we received showed students had been signposted to support services to help them manage their care and treatment when it had been needed. This included the university student support service, Eating Disorders in Students' Service (EDISS), voluntary organisations related to bereavement, drug and alcohol use for example. Notices in the patient waiting room and practice website also told students how to access a number of support groups and organisations such as the Samaritans.

Staff told us GPs offered home visits for students experiencing poor mental health and also liaised with the local mental health teams to ensure they could access appropriate support. GPs we spoke with told us an open appointment for follow-up was offered to patients that had experienced bereavement. This appointment included time spent listening to the patient and making appropriate referrals for talking therapies and / or counselling if the patient wished. The practice were in the process of resuming quarterly meetings with counsellors, a professor in psychiatry and the university; as part of improving coordinated care and support for people with mental health needs and / or requiring emotional support.

The practice also assessed patients with long-term conditions for anxiety and depression, and this was recorded on the patient record. The practice had a triage system in place and staff told us emergency appointments were offered to patients requiring support in relation to their emotional needs. Two comment cards reviewed confirmed urgent appointments were made available when one patient was experiencing deep anxiety and another was feeling overwhelmed with university life.

The practice had a lead GP for carers, and the computer system alerted GPs if a patient was a carer. There was written information available for young carers to ensure they understood the various avenues of support available to them.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The 2013/14 practice patient survey showed most of the 365 respondents were satisfied with the services offered by the practice. For example, the key results were: 83% of students described their experience of accessing the surgery as very good; 86% had confidence and trust in the GP or nurse they saw; and 80% said GPs and nurses were good at giving them enough time to discuss their care needs. 74% of students rated nurses as good at explaining tests and treatments; and 72% said they were involved in decisions about their care.

The results related to how easy it was to speak to a GP or nurse on the phone and obtaining same or next day appointments showed improvements could be made. Most of the patients we spoke with told us their medical needs were always responded to with the right care and commended the practice's efforts at providing health information during the university registration week.

We found the practice was responsive in addressing the student population health needs and had robust systems for monitoring the services provided. An area of outstanding practice included the practice's responsiveness in carrying out opportunistic screening and testing of sexual health infections such as chlamydia. This included: at the point of student registration in September and October of each year; visiting individual halls of residence once a week in the evening, and when patients were routinely seen by the GP and nurse.

Staff told us "taking the services into halls of residence" was both a responsive and effective initiative to empower students to manage their sexual health. Two students we spoke with felt these opportunistic interventions had given them a lot of information and had made a positive impact to their health and wellbeing.

The practice worked in liaison with the Glasshouse Street Health Centre (young people's drop in clinic for contraception and sexual health) in treating and contact tracing for chlamydia. Contact tracing involves finding and informing the contacts of a person with an infection so they can get information, testing and treatment. A GP we spoke with told us contact tracing of sexual partners was an important part of the clinical management of sexually transmissible infections.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice regularly engaged with them and other practices, to discuss local needs and care that needed to be prioritised. We saw CCG reports where this had been discussed and actions agreed to implement service improvements. For example, the practice's 2013/2014 actions were to improve the "did not attend" (DNA) appointment rates and to reduce avoidable A&E attendance by patients with alcohol related issues. A policy was in place where students who had attended A&E for a second occasion were identified and invited to come in for a review of their health needs to ensure they received appropriate care within the community.

The university student health development officer told us the student service had positive working relationships with the practice and found staff were responsive to referrals made and concerns raised about patient care. The officer also participated in quarterly meetings with the GPs to discuss patient care needs and any support that was required.

The GPs we spoke with gave examples of how their practice had collaborated with Public Health and Nottingham Trent University to improve disease prevention amongst the student population. This included the coordination of care and treatment related to outbreaks of mumps. The practice provided the MMR (Measles, Mumps and Rubella) vaccines which are used to prevent mumps as well as health information advice.

The Nottingham Trent University also notified the practice if there are any reported cases of patients with meningitis and tuberculosis for example. This information was then used by the practice to follow-up and offer booster jabs, as well as promote health and well-being amongst the students.

The practice had identified asthma, diabetes, epilepsy, hyperthyroidism and rheumatoid arthritis as the main long term conditions the student population experienced. In response to this, the practice undertook regular reviews and care planning. The practice also worked with the community nurse for diabetes to ensure patients received appropriate care.

The practice was flexible in terms of the care and treatment it provided for the student population. For example, asthmatic patients received an annual check and were reviewed as required without having to attend a

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

designated asthma clinic. In addition, one of the practice nurses had qualified to initiate insulin and they were due to start their role the week of our inspection. Staff we spoke with also told us that patients who were having difficulty in controlling their asthma attacks were offered urgent appointments.

GPs told us they had noted an increasing number of students with mental health needs. In response to this, a multi-disciplinary team meeting had been planned for 11 November 2014 to discuss the concerns with counsellors, a professor in psychiatry and student support centre. One GP told us a holistic approach to treatment and support was provided to patients with mental health needs; and internet based strategies and talking therapies were preferred by patients.

The practice was also involved in a research project which included identifying young people that had self-harmed and with their involvement developing self-help literature to help other patients. While this was a good initiative, we could not evaluate the impact on patient care as the project was still in progress. Patients could still access information on self-harm from the practice website.

### Tackling inequity and promoting equality

Students were able to easily register with the practice and were encouraged to do so before starting university in September. For example, an information pack was sent to the home address of all new students who had expressed an interest in registering with a local doctor. This initiative was to ensure that students were fully registered by the time they arrived in Nottingham.

The premises and services had been adapted to meet the needs of people with disabilities. This included automatic doors at the front entrance, ramp access for wheelchair users, and portable hearing loops can be provided on request. The practice had received an inspection by "Disabled Go" and their report showed the practice had good access for patients with disabilities. Disabled Go is the leading provider of access information for disabled people in the UK and produces a comprehensive online disabled access guide to healthcare premises. We found treatment and consulting rooms were located on the ground floor; and accessible toilet facilities were available for all patients attending the practice.

All students were able to communicate in English as this was a requirement for university entrance. However, the fluency of English varied amongst the student population; and one student told us they felt more confident speaking in their own language. To address this need, the practice had access to translation and interpreting services if required. We saw that students were prompted to choose a language of their choice when using the self-check in machine to confirm arrival for their appointment.

One international student we spoke with gave positive feedback about the support they had received to register with the practice, as well as the care and treatment received. We saw that international students were provided with leaflets covering areas such as the role of GPs, their function as gatekeepers to the health services, how to register and how to access emergency services.

This information was available in a range of languages including Chinese, Spanish, Punjabi and Arabic. Some of the GPs also spoke other languages such as French and Urdu, which enabled them to communicate with patients without a need for an interpreter. Training records reviewed showed staff had completed the equality and diversity training and that equality and diversity was discussed at team events. The practice had a system for flagging vulnerability in individual patient records so that staff were aware of any issues relevant to their care and treatment.

### Access to the service

The practice had recognised the needs of the student population in the planning of its services. We found patients could make appointments in a number of ways; this included attending the practice in person, requesting an appointment over the telephone or booking an online appointment (once they had registered for this service). Patients who used the online booking system stated it was easy to use, and found the text message reminders for appointments and test results very useful. The practice had made changes to the appointment system in response to feedback from the patient participation group (PPG).

The practice was open Monday to Friday and the opening hours were clearly displayed, both within the practice and on the practice's website. The term time opening hours were between 8.30am and 6.45 pm four days a week; and the practice was open between 8.30am and 1pm on a Thursday. The opening hours during university holidays were reduced to between 8.30am and 5.00pm due to low demand as most students lived off campus. Students we spoke with felt the opening hours were suitable as they

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

could access the practice outside university and working hours. This was also reflected in the 2013/14 practice patient survey, which showed 89% of 365 respondents felt opening times were convenient for them.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. For example, if patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. This included emergency services such as the ambulance and NHS direct; as well as the practice's contracted out of hour's provider NEMS.

Longer appointments and home visits were also available for people who needed them and this included people with mental health needs and long-term conditions. This also included appointments with a named GP or nurse. The practice acknowledged that not many home visits were requested by the students as the practice was on campus therefore easily accessible. The CCG also provided a home visit service for any patient that needed to be visited urgently but not needing ambulance / emergency services before 12 noon.

All the people we spoke with and most of the comment cards received showed patients were satisfied with the appointment system and the waiting time. Some people felt improvements were still required to reduce waiting time within the practice. Patients confirmed they could see a doctor within 48 hours if they needed to, and they could see another doctor if there was a wait to see the doctor of their choice. Five out of 48 comment cards indicated patients sometimes found it difficult to get appointments when they rang at 8am.

Comments received from patients showed they could usually get urgent appointments on the same day of contacting the practice. If this was not possible, we saw that a nurse led triage system was in place to prioritise emergency and phone consultations for patients who were not well. One nurse we spoke with told us the practice was flexible to ensure that patients were seen in a timely way and by the appropriate health professional. Some patients said that the call-back service was very helpful, whilst others felt this could delay accessing an earlier appointment whilst waiting for a call back. The 2013/14 practice patient survey showed 67% of patients were seen the same or next day and 21% within two to four days.

Discussion with the staff and a review of electronic records showed the demand for appointments was regularly reviewed and additional appointments added when needed. For example, two or three emergency appointments were added per GP session in response to patient needs. A GP told us they offered emergency appointments on Friday evenings and on occasions, this extended beyond the opening hours of 6.45pm.

### Listening and learning from concerns and complaints

Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint and most students said they would speak with their GP or the practice manager. None of the patients had ever needed to make a formal complaint about the practice. We saw that information was available to help patients understand the complaints system. This included the complaints procedure being displayed in the waiting room and on the practice website for patients to access.

We found the practice had a system in place for handling complaints and concerns. This included acknowledging complaints received and providing patient feedback after an investigation. The practice manager was the designated responsible person who handled all complaints in the practice. Records reviewed showed the practice had received two formal complaints since October 2013; and these had been investigated and responded to appropriately. Meeting minutes of the practice's learning events showed complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

The practice vision was as follows: "We aim to provide the highest level of care to our whole patient population; ensuring that care is specific to individual needs; patients are treated equally with dignity and respect; and by a suitably skilled and motivated team." Our discussions with both clinical and non-clinical staff showed this vision was shared as a team and embedded in practice.

The vision was also underpinned by objectives such as: keeping up to date with current and new treatment according to the National Institute for Health and Care Excellence (NICE) guidance; supporting patients to maintain a healthy lifestyle and making positive changes in response to patient feedback. We saw examples of how these objectives were being implemented by staff to improve the quality of care for patients. In particular, health promotion, diabetes care and changes to the appointment system.

Records reviewed showed staff discussed different aspects of the practice vision and strategies at their regular team meetings. However, this was not always integrated into a formalised business plan which would support the practice in evaluating the overall progress in achieving its vision; as well as ensuring the objectives were still relevant.

The practice leadership acknowledged that the focused exercise to prepare for the inspection had enabled them to appreciate more of "what we do well" and review future plans to address areas of identified improvement. The practice was also involved in the Clinical Commissioning Group (CCG) funded research projects aimed at improving the care of asthma patients, patients with mental health needs and at risk of self harm.

### Governance arrangements

We found a number of policies and procedures were in place to support staff and govern activities undertaken within the practice. All the policies we looked at had been reviewed and were up to date. This included clinical governance, recruitment, prescribing of medicines and safeguarding policies.

Staff we spoke with knew where to find these policies when required. Staff had received information governance training and were aware of their duty of care in managing confidential information. Staff knew who the GP lead for governance was and felt they were open and approachable to discuss any issues.

The practice participated in a local peer review system with neighbouring GP practices and also received a visit from peer GPs. The GP visits were part of the Nottingham City CCG capacity building visit programme. This programme aimed to ensure that practices used a variety of information sources to investigate and reflect upon their performance management in relation to commissioning budgets and patient care.

The practice showed us their 2014 visit report completed by the Nottingham City CCG. This report showed the practice had made positive achievements in continued education of patients about the appropriate use of accident and emergency (A&E) services for example. As a result, the practice rate of avoidable attendances (where patients are discharged from A&E without treatment or follow-up) had reduced since 2011 and was fairly low compared to other city practices.

The practice used the Quality and Outcomes Framework (QOF) and eHealthscope data to measure its performance. QOF is the annual reward and incentive programme detailing GP practice achievement results. EHealthScope is an information analyser that provides information required to deliver good patient care. It covers aspects of Public Health Commissioning and clinical governance.

The QOF data we held for this practice was combined with another location's (Radford Medical Centre – Kaur) practice data, which was owned by the same provider. Radford Medical Centre – Kaur is registered as a separate location by the Care Quality Commission therefore not inspected. We therefore relied on the practice and Nottingham City Clinical Commissioning Group (CCG) records to assess the practice's QOF performance.

The CCG report for practice visits undertaken in May and June 2014 showed the 2013/14 clinical QOF achievements for the practice included improvements around lowering blood pressures for patients with a diagnosis of diabetes and hypertension.

We saw that clinical audits were also used to monitor the quality of services that patients received. This included auditing the reasons for prescribing specific medicines and checking that GP prescribing was in line with local and

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national guidelines. The practice management had future plans to hold regular clinical meetings with standing agenda items such as NICE guidance, audit work and clinical protocols as they felt it was an area of improvement.

The practice had suitable arrangements in place for identifying, recording and managing risks. We saw that risk assessments related to the building and fire had been produced for example; and a health and safety audit had been planned for December 2014.

### Leadership, openness and transparency

The practice had a clear leadership structure in place with named members of staff in lead roles. For example, there was a lead nurse for infection control, the senior partner was the lead for safeguarding and one GP had a specialised interest in dermatology care. The GP partners and nurses led on clinical matters, while the practice manager and their deputy led on staffing, administration and financial matters. We spoke with twelve members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew whom to go to with any concerns.

Staff we spoke with told us a team working approach was promoted; and as a result they had good working relationships. The management also reported having a very loyal and experienced team with many of the staff have worked at the practice for many years. This ensured continuity of care for patients.

The practice held weekly GP partner meetings and regular team meetings. Staff told us they enjoyed their work and there was an open culture within the practice which enabled them to raise any issues at team meetings. The management told us future planning was regularly discussed in practice meetings to ensure improvements in service delivery and patient care; however this was not formally documented. This included managing the practices financial challenges, options to recruit permanent staff in response to an increasing patient list size and taking part in CCG led research projects relevant to the student population.

The practice manager and her deputy were responsible for human resource policies and procedures; and participated in online discussion forums for practice managers. They told us this ensured they were up to date with policies and employment law for example. The managers also attended regular meetings with other managers from neighbouring GP practices so as to inform improvements to the practice systems, performance and staff development.

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

We inspected the practice at the beginning of the university term when there were changes to the student population. As a result, we found the practice in the process of updating its 300 member virtual patient participation group (PPG) and advertising for new members with a view to increasing the group. A PPG is group of patients who engage with practice staff to identify priorities for patients, and contribute to proposals for any service improvements.

Records reviewed showed PPG involvement was mainly via email which was the preferred method by students. The practice had gathered feedback from patients through patient satisfaction surveys, NHS Choices website, complaints and compliments received; as well as feedback from Nottinghamshire Eating Disorder Service.

The practice manager showed us the analysis of the 2013/14 patient survey and the action plan, which were agreed together with the PPG. The practice had received an overall positive response to the practice survey; in particular 94% of respondents found reception staff helpful, 89% were happy with opening times and 67% were seen within 48hours.

The results and actions agreed from these surveys were clearly displayed in the waiting area with signs stating “you said” and “we did”. For example, patients said there had been an increased promotion of online booking appointments and the prescription ordering service. In response to this, the practice invited patients to sign up for these services and information was made available on the practice website and in a leaflet.

The practice gathered staff feedback in practice meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff. However, staff said they had no cause to use it. Feedback

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received from two staff members based at the Nottingham Trent University student support service was complimentary of the care provided and joint working arrangements.

### Management lead through learning and improvement

Staff told us the practice supported them to maintain their professional development through training and mentoring. This was supported by the training records reviewed. Practice learning and training events were regularly held to provide support, training and updates for staff; and online training resources were also available. Records reviewed showed topics discussed at CCG learning events included mental health, prescribing for non-clinical staff and the shape of the new NHS.

Staff could also attend Nottingham Trent University training events and the student health association conferences. Staff files we looked at showed annual appraisals took place which included a personal development plan. The practice managers also helped with training halls of residence representatives in regard to accessing the service and student health services.

The practice had completed reviews of significant events and other incidents, and this was shared at staff meetings to ensure the practice improved outcomes for patients. For example, the practices processes were changed following significant events related to processing of urgent referrals, patient information and sharing of test results with patients.