Adam House Medical Centre

Quality Report

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Date of inspection visit: 28 January 2015
Date of publication: 11/06/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 28 January 2015 as part of our new comprehensive inspection programme. This is the first time we have inspected this practice.

The overall rating for this practice is good. We found the practice to be good in the safe, effective, caring responsive and well led domains. We found the practice provided good care to people with long term conditions, families, children and young people and people in vulnerable circumstances, older people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients told us they were satisfied with the appointments system and told they could see a GP when they needed to.
- Patients were kept safe from the risk and spread of infection as the provider had carried out audits and acted on their findings
- Patients were treated with dignity and respect and spoken to in a friendly manner by all staff
- Systems were in place to keep patients safe by assessing risk and taking steps to reduce this. We saw evidence of learning from previous incidents.
- Patients, their relatives and carers were involved in all aspects of treatment and their opinions were listened to and acted upon.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice had a very active and involved Patient Participation Group (PPG) carried out all patient surveys which included patient experience of individual clinicians

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

The provider should:

- Ensure that all audits cycles are completed by ensuring a second cycle is carried out to demonstrate whether improvements had been made following re-audit.

Summary of findings

- Clinical supervision should be provided for all clinical staff including nurses to enable and support their continuous professional development.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Robust safeguarding systems were in pace to protect children ad vulnerable adults from harm. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe. Processes were in place to check medicines were within their expiry date and suitable for use.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the CCG area. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs have been identified and planned. However we noted that one member of clinical staff did not higher level safeguarding qualification.

The practice could identify all appraisals and the personal development plans for the majority of staff, although one nurse told us they did not receive formal clinical supervision. Staff worked with multidisciplinary teams to ensure the best outcomes for patients. For example the CCG prescribing advisor visited the practice weekly to review medicines and prescriptions.

Are services caring?

Good

The practice is rated as good for providing caring services. Survey data showed that patients rated the practice higher than others for several aspects of care, particularly for involvement in care and clinical staff explaining decisions. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. For example the building had level access and toilets which were accessible to people in wheelchairs, parents with push chairs and those with reduced mobility. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Practice staff had access translation services to assist people for whom English was not their first language. Learning from complaints with staff and other stakeholders was discussed at team meetings.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. We observed how people were being cared for and talked with carers and family members. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people such as rheumatoid arthritis and coronary heart disease. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice offered screening for dementia for patients considered to be at risk. Additionally the practice supported CCG employed Advanced Nurse Practitioners working in local care homes

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice PPG held information sessions for patients with long term conditions along with regular clinics for diabetes, COPD and asthma.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. Additionally the practice held regular baby clinics, offered the HPV vaccine and held bi monthly health visitor meetings.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered extended opening hours one day a week and patients were able to access a nearby walk in centre up to 8pm. Patients over 40 were invited for a cardiac health screen.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 67% of these patients had received a follow-up. This number was higher than the local and national average. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 87% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE, two organisations that offer support and advice to people who have poor mental health and

Summary of findings

their families. It 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 had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Prior to our inspection we left a comment box and cards for patients to complete. We received 37 completed comment cards. Of those we received 33 had wholly positive comments, expressing views that the practice offered an excellent service with understating, caring and compassionate staff, and committed, caring GPs. There were two cards which included positive comments but raised concerns about appointment times. Two comments were from NHS professionals attached to the practice, making positive comments.

The practice had conducted a patient survey. The data collected related to two periods during 2014 – March and October. The surveys showed the majority of patients were happy with access to the service and the care and treatment they received. In addition the national patient survey from July 2014 showed that 108 patients had taken part. Comments were generally very positive. 78% of patients who responded described their experience of making an appointment as good, 90% had confidence and trust in the last GP they saw or spoke to and 73% described their overall experience of this surgery as good.

We spoke with six patients during our inspection. All six patients said they were happy with the care they received, three were extremely happy, and all six thought the staff were all professional, approachable, and caring.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all audits cycles are completed by ensuring a second cycle is carried out to demonstrate whether improvements had been made following re-audit.
- Clinical supervision should be provided for all clinical staff including nurses to enable and support their continuous professional development.

Adam House Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector. The lead inspector was accompanied by a second inspector, two GP specialist advisors plus a practice manager specialist advisor.

Background to Adam House Medical Centre

Adam House Medical Centre provides primary medical care services to approximately 7,200 patients. The practice is based in a building on the outskirts of Nottingham close to the M1 motorway. There is a smaller branch surgery, Hillside Medical Centre approximately three miles away although we did not visit this during our inspection.

The practice has a Primary Medical Services (PMS) contract with NHS England. This is a contract supporting the practice to deliver primary care services specifically tailored to the local community or communities additional to those provided under the General Medical Services (GMS) contract.

There are three GPs at the practice, two are partners, and one is a salaried GP. There are two male GPs and one female GP. In addition the nursing team comprises of three nurse practitioners, three practice nurses, one specialist cardiac nurse and one healthcare assistant. The practice also employed a midwife and two phlebotomists. The clinical team are supported by the practice manager and an administrative team.

Adam House Medical Centre has opted out of providing out-of-hours services to its own patients. Out-of-hours services are provided by Derbyshire Health United through the 111 telephone number.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 January 2015. During our visit we spoke with a range of staff (GPs, nursing staff and administration and reception staff) and spoke with patients who used the service. We observed how people were being cared for and talked with six patients We reviewed 37 comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a patient was inappropriately invited for a vaccination. The reasons for this occurring were explored and this was remedied and action taken to ensure this did not happen again. The GP partners demonstrated a sound knowledge of their responsibilities in managing significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. For example the records in the accident book had been recorded for a number of years. These records included the outcome and action taken by the practice. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. We also saw that RIDDOR reports (Reporting of injuries, diseases and dangerous occurrences regulations 2013) were completed on-line when necessary.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held weekly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system she used to manage and monitor incidents. We tracked 14 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. One example was inappropriate filming in the waiting room. This was discussed at a practice meeting and a sign was placed in the waiting room stating mobile phones should not be used.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. For example, we saw that a patient experienced delay in transfer to hospital due to communication failures between the practice and the ward. Records showed the patient received an apology from the practice and that a new system for requesting transport and informing patients was implemented and communicated to all staff.

National patient safety alerts were disseminated to practice staff. 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 shared with staff and discussed at practice meetings to ensure all 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 to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead for safeguarding both vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role, we saw evidence that GPs had been trained to level 3. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. However we noted that one member of clinical staff had not received updated safeguarding awareness training to a level appropriate to their role. Following our inspection evidence was provided to show this training had been booked.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example frail patients had a 'rightcare' plan in place which ensures clear communication of patients condition and needs when transferring between services, for example when using the out of hours service.

The practice had identified and followed up children, young people and families living in disadvantaged circumstances (including looked after children, children of patients who misused drugs and young carers.) Regular multi-disciplinary meetings with the health visitor, school nurse and practice staff were held every other month to ensure information sharing, continuity of care and risk management.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GPs were aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

The practice had a chaperone policy. There were clear notices on consulting room doors about the use of chaperones. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, six administrative staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines Management

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

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example non-steroidal anti-inflammatories. The prescribing lead from the CCG came into the practice every Monday to advise on prescribing criteria within the practice and to ensure that NICE guidance was followed. We saw evidence indicating the practice had been pro-active in reducing rates of antibiotic prescribing and the use of non-steroidal anti-inflammatory medicines (NSAIDs). NSAIDs are a group of medicines that provide pain relief and fever reducing effects, the medicines can cause stomach problems, and their long term use should be avoided.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits of the quality of cleaning and the

safe and effective use of sharp boxes during the past six months. Improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

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. For example, personal protective equipment was seen in clinical areas, and we observed staff using this. There was also a policy for needle stick injury,

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example two electro-cardiogram machines (a machine for recording the heart's electrical activity) and the fridge thermometer. We saw invoices to evidence that calibration of all necessary equipment had taken place.

Staffing & Recruitment

We looked at four staff records. All four contained evidence which showed that appropriate recruitment checks had been undertaken prior to employment. For example, photographic proof of identification, references from previous employment, qualifications, and registration with the appropriate professional body where required. We saw that the practice had a system in place to monitor the continuous maintenance of this registration. We saw that all staff had up to date criminal records checks through the Disclosure and Barring Service (DBS).

We saw that the practice had a recruitment policy in place which set out the process it followed when recruiting and interviewing clinical and non-clinical staff.

Staff told us they felt they had enough staff to carry out their duties and meet the needs of patients. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Monitoring Safety & 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager shared findings from significant events and complaints analysis with the team.

The practice had worked with the out-of-hours provider to develop care plans for patients most at risk of hospital admission and those who would require care or treatment when the practice was closed. The practice showed us records of how the care plans had proved helpful for patients and the out-of-hours provider.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that approximately half of the staff had received training in basic life support. Training was booked for the remaining staff and was due to take place in March 2015. Emergency equipment was available including access to oxygen and an automated external

Good

Are services safe?

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.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest; anaphylaxis and hypoglycaemia The practice did not routinely hold stocks of other medicines for the treatment of emergency situations. Additionally GP's did not routinely carry these medicines in their doctor's bags on home visits. In such situations we were told that as the practice was in an urban area and located less than a mile from an ambulance station, staff would dial 999 and summon an ambulance. We saw that a full risk assessment had been undertaken and a protocol was in place to manage this. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. We saw that this plan was reviewed in March 2014 with a further review due in march 2015. Each risk was rated and mitigating actions recorded to reduce and manage the risk, including transferring all activity from the main site to the branch surgery. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Additionally a fire safety assessment had been completed by a registered fire safety consultant. Records showed that staff were up to date with fire training and that they practised regular fire drills. However, we observed one fire exit was partially obstructed by furniture. The provider informed us they would make immediate changes Following our inspection the practice provided evidence that changes had been made to the fire exits and access was now clear and unobstructed

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. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw that all NICE Guidelines and updates were discussed at clinical meetings and then further disseminated to staff via the Practice Nurse. We saw that further discussion of updates was held at regular GP feedback sessions. We found that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. This was particularly so for medicines management, where medicines were discussed with the prescribing advisor from the CCG on a weekly basis, and followed up at the weekly practice meeting.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers, and emergency admissions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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 was 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 clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us six clinical audits that had been undertaken in the last year. We saw that only one audit, looking at 24 hour urine collection awareness, had completed two cycles audit with clear results and commentary shared with clinicians and other staff. However, not all of the clinical audits were completed cycles which demonstrated clearly improved outcomes for patients following reaudit.

The practice used the information collected for the quality and outcomes framework (QOF) to assess their performance. QOF is a national performance measurement tool. They also considered their performance in relation to national screening programmes to monitor outcomes for patients. The practice performed well in relation to these measures, for example 91.1% of patients with a diagnosis of COPD (Chronic obstructive pulmonary disease, which is a lung disease) had been reviewed and assessed by a healthcare professional in the previous 12 months, and the practice met all the minimum standards for QOF in clinical indicators for stroke, asthma and epilepsy.

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.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance

was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was working towards the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example the practice compared favourably with other practices in the local area in respect of the number of completed annual reviews in respect of patients with learning disabilities and the support and treatment of patients with depression.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with mandatory training although half of all staff required updated annual basic life support training. All GPs had experience and qualifications in minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (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).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a member of staff had identified a phlebotomy course they wanted to attend, which the practice was supporting. As the practice was a teaching practice, medical students who were training to be doctors spent time at the practice learning from the GPs.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and were aware of their limitations and willing to seek advice when needed. Those with extended roles for example seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings weekly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses,

social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We received feedback from two health professionals of external agencies who worked with practice staff. They told us they felt communication from the practice was second to none and noted this was the only practice in their experience that included non-clinical and clinical staff at meetings which ensured communication, requests and referrals were dealt with in a timely manner.

Information Sharing

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. Electronic systems were also in place for making referrals, and the practice made over 90% of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by Summer 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. There was a policy on consent and this policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. The practice used Right Care (a shared decision making programme instigated by the NHS for people in vulnerable circumstances) to record decisions and share information with other healthcare providers, particularly in emergency situations.

Patients with a learning disability and those with dementia were supported to make decisions through the use of Right Care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice demonstrated that 100% of patients with a learning disability had been invited for a review in the past 12 months. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP or practice nurse was informed of any health concerns detected to which ever clinician was most appropriate, and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve

Good

Are services effective?

(for example, treatment is effective)

mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 1,420 patients out of 2,620 in this age group took up the offer of the health check. A GP showed us how patients were followed up in a timely manner if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed there were 44 patients registered at the practice who had a learning disability. All had been invited for a check-up with 20 of these patients having received a check up in the last 12 months.

Care coordination meetings organised by the CCG were hosted at the practice every two weeks. These were attended by; district nurses, community matron, community mental health, social services, drug and alcohol team and GP's. These meetings discussed patients with complex needs who may require additional support. We were told that relatives and carers of patients were invited to the meetings. Health care professionals told us they found the input and communication from GP's and staff at Adam House to be exemplary.

The practice had also identified the smoking status of 100**%** of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. This was above average compared to neighbouring practices and national figures. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was above the national average, with 85% of women having a record of a smear test in the last five years compared to a national average of 77%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice kept a register of patients who are identified as being at high risk of admission, which is part the enhanced service for hospital admission avoidance. Practice data claimed that the practice was the only one in the CCG area to achieve a target of 2%.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 108 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national 2014 patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice performed well in relation to patient satisfaction scores on consultations with doctors and nurses with 72% of practice respondents saying the GP was good at listening to them and 74% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive stating difficulty in accessing appointments. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that a private room was available for patients discuss issues confidentially. We observed telephone conversations between reception staff and patients. At all times patient confidentiality was maintained and complete checks on patient identity were carried out at the start of conversations.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients were generally happy with their involvement in planning and making decisions about their care and treatment. For example, data from the national patient 2014 survey showed 67% of practice respondents said the GP involved them in care decisions and 74% felt the GP was good at explaining treatment and results.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The 2014 survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke to on the day of our inspection and the comment cards we received showed that patients were happy with the support they received and access to care.

The practice informed us that if patients with life limiting conditions or cancer moved away from the practice area, they were kept on the practice list to ensure continuity of care and preserve the existing relationship.

Good

Are services caring?

Patients we spoke with told us they felt supported by the practice and felt they had a good relationships with their GP. One patient told us how one of the GP's had arranged additional support for their family member who had multiple conditions. The GP then arranged carer support for the family to assist them.

Notices in the patient waiting room, and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful. The practice made referrals to Treetops and CRUISE which were support services for the bereaved.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used the Clinical Commissioning Group (CCG) recommended risk tool, which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made by a named GP to those patients who needed one.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, the PPG survey identified that patients were unhappy with the appointment system. The practice implemented a nurse triage system which improved patient satisfaction. Additionally, a complaint was made via the PPG that the practice did not open at the advertised time for afternoon sessions following training. The practice changed its operating procedures to ensure the doors were open. Also, the PPG asked for a staff photo board. The practice agreed and PPG members took the photographs.

The practice was working towards the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. The practice held a Multi-Disciplinary Team meeting every two weeks to discuss end of life care and patients with additional support needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had access to online and telephone translation services and GPs spoke four languages apart from English. In addition one GP was proficient in British sign language although we were not told if patients used this service.

Practice staff had access to online equality and diversity training, which must be completed annually. During our inspection we observed staff treating patients with dignity and respect and did not observe any discriminatory behaviour.

The premises and services had been adapted to meet the needs of people with disabilities or those with reduced mobility. All service were provided on the ground floor of the building, with was stepped access to the first floor. The GP's were aware of the limitations of their premises and had taken steps to make reasonable adjustments for people with disabilities. For example the practice had a ramped access, however, the front door was not user friendly for a person in a wheel chair, as the door had a closer fitted and required being opened manually. Level access toilets were available with sliding doors enabling ease of access.

The practice had a population of 96% English speaking patients though it could cater for other different languages through translation services.

Access to the service

At Adam House Medical Centre appointments were available from 08:00 am to 6:30 pm on weekdays. Emergency appointments were available at the end of both morning and afternoon surgeries. In addition the practice operated a later evening surgery until 8:00 pm on Thursdays (with a GP). The practice's extended opening hours on Thursdays until 8:00 pm was particularly useful to patients with work commitments. This was confirmed by

Good

Are services responsive to people's needs?

(for example, to feedback?)

comments we reviewed and patients we spoke with. One comment indicated that the patient found the appointment system amenable to their lifestyle and welcomed the availability of late appointments.

Patients were also able to access medical services after the practice had closed at 'the Hub'. This was the name given to a local open access service that operated from Long Eaton Health Centre or Ilkeston Walk in Centre from 5:30 pm to 8:00pm Monday to Friday. Appointments for this service were booked through the practice or patients were able to sit and wait for an appointment

The practice was closed for staff training every Tuesday between 1:00 pm and 2:00 pm. The branch surgery offered appointments between 08:30 am and 6:00 pm four days per week, and 08:30 am until 1:00 pm on Thursdays. The main site opened on Saturday morning for the collection of prescriptions, although no appointments with clinical staff were available at the weekend.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. 2014 patient survey data showed that 92% of patients described their experience of contact the practice via telephone as good. Additionally 78% of patients described their experience of making an appointment as good. Both these figures were significantly higher than the CCG averages. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. Patients we spoke with told us they were able to get same day appointments if they telephoned the practice in the morning. They told us this may not be with the GP of their choice but all were satisfied with the service offered.

Listening and learning from concerns & complaints

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

We saw that information was available to help patients understand the complaints system, a leaflet and a poster was available outlining the complaints procedure. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 10 complaints received in the last 12 months and found that they were handled in a timely way and in line with the practice complaints policy. All 10 complaints showed evidence of thorough investigation involving several members of staff and appeared to have been resolved to the complainant's satisfaction.

The practice reviewed complaints annually to detect themes or trends. This review was shared with staff and available to patients and the public on request. We looked at the report for the last review which identified half of all complaints related to clinical care with the majority of complaints raised by a relative or carer of the patient. We saw that lessons learned from complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. The practice vision and values aimed to provide safe effective patient centred care by establishing strong GP relationships with patients and the community

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Staff told us they were proud to work at the practice and had a sense of ownership for the vision and values.

Governance Arrangements

The practice had policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies and procedures including the chaperone, recruitment and safeguarding policies. Staff we spoke with told us they were aware of most policies and how to access them we saw that although some policies were recently updated not all indicated who was responsible for their review and implementation.

There was a leadership structure in place with named members of staff in lead roles. For example, there was a lead nurse for infection control and there was a lead partner for safeguarding children and Caldecott Guardian. There was also a GP partner who was lead for safeguarding vulnerable adults. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. All staff told us they felt valued and well supported. However the majority of staff we spoke with told us they did not always know which member of management to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in within the CCG.

The practice had undertaken clinical audits and reviews which it used to monitor quality and systems to identify where action should be taken. For example reviews of repeat prescriptions, the electronic prescription system, use of anti-inflammatory medicines and risk of stomach pains.

The practice held bi-monthly governance meetings for the partners. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, whistle blowing, induction policy, management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through comments cards, patient surveys and online comments and complaints received. We looked at the results of two patient satisfaction surveys carried out by the PPG in March and October 2014. These showed that all patients who responded were happy with the care and treatment they received

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups. The PPG had carried outpatient surveys every six months and met regularly. The practice manager showed us the analysis of the last patient survey, which was designed, carried out and analysed by PPG members. Surveys looked at patient experiences of individual clinicians. Once analysed the findings were fed back to each clinician by a member of the PPG. Staff told us that although this could be understandably uncomfortable, it

Are services well-led?

Good

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

had helped to develop both clinicians and the practice itself and was something they welcomed. The results and actions agreed from these surveys are available on the practice website.

The PPG worked closely with the practice and was very much representative of the local community. By using these connections members had worked with the practice to develop a range of health promotion and information events including; dementia awareness, cardiac health sessions, diabetes, coping with respiratory problems and ways the practice can support patients. Each session was held at a local Methodist Hall to allow greater numbers of patients to attend. We saw that these events were attended by a health professional and members of the practice team.

The PPG had developed an initiative called 'Slimathon'. This aimed to help patients improve their health through a collective weight loss programme. The initiative had received the backing of the CCG and was scheduled to be rolled out to all practices in the area in August 2015.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or colleagues and management and that they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us they were able to ask for additional training for their role. One staff member told us they had requested training to enable them to take blood from patients to improve the efficiency of testing. We saw this was authorised.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. A Nurse practitioner had received support from the practice to complete her masters in nursing. The practice was also in the process of formulating the clinical supervision for the nurses.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

For example prescribing errors or errors with summarising of information. We saw that an action plan was developed and implemented for each significant event investigated.