NEMS Platform One Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at NEMS Platform One Practice on 30 June 2015. Overall the practice is rated as outstanding.

We found the practice was good for providing safe services and outstanding for providing caring, responsive and effective services and for being well led. It was also outstanding for providing services for the six population groups.

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

- The practice population was very diverse. It included a high transient population and numbers of patients who were vulnerable, homeless, seeking asylum, misused substances or had poor mental health.
- The staff team were highly responsive to meeting patients' needs and engaging with hard to reach groups, to improve their welfare and reduce health inequalities.
- Feedback from patients was continually positive about the care and treatment they received and the way staff treat them. Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment when they needed it, and could access appointments and services in a way, and at a time that suited them. The practice provided a transport service to patients who struggled to attend appointments.
- The practice used innovative and effective ways to improve outcomes for patients. High importance was placed on improving patients' health by offering various screening checks and regular health reviews.
- The services were tailored to meet people's individual needs and delivered in a way to ensure flexibility, choice and continuity of care. The staff team worked collaboratively with other services to meet patients' needs, and support vulnerable individuals.

Summary of findings

- The practice was safer than other similar practices as people were protected by comprehensive systems to help keep them safe. There was a pro-active approach to anticipating and managing risks, and a focus on openness and learning when things went wrong.
- The practice actively sought the views of patients and staff and implemented improvements to the way it delivered services in response to feedback.
- The practice had a large staff team, which continued to increase in size and skill mix to meet patients' needs and the expansion of the service.
- The practice had a highly motivated and committed staff team who worked well together. Staff were actively supported to continually develop their knowledge and skills to ensure the delivery of high quality care.
- The practice was exceptionally well-led. The management and governance of the practice assured the delivery of high-quality person-centred care.
- The culture and leadership empowered staff to carry out lead roles and drive continuous improvements. High standards were promoted and owned by all staff.

We saw several areas of outstanding practice including:

- The practice provided a wide range of services to meet patients' diverse needs. For example, 25% of patients had poor mental health. The practice had developed its own primary mental health services, which included a lead GP and two experienced nurses. One of which was a prescriber and the other was a psychotherapist, which enabled them to offer a broad range of treatments to patients.
- In addition, the two GP leads for substance misuse held weekly shared care clinics, which enabled patients to be treated at the practice. The clinic held at the branch surgery was extended to non-registered patients; seven out of 27 patients attending this were not registered with the practice.
- The practice had high numbers of patients who were asylum seekers. The practice was working with public health and the local charity for refugees and asylum seekers, to develop a multilingual booklet, which would enable families from overseas to understand the National Health Service.
- High importance was placed on educating patients to self-manage their conditions. For example, the practice had implemented a City wide initiative, which demonstrated the use of inhalers by video, and simple physiotherapy exercises for the benefit of patients with asthma and musculoskeletal conditions.

Importantly the provider should:

Develop the clinical audit programme to ensure that all audits are completed to a consistent standard to provide assurances that patients are receiving effective care and treatment.

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.

Patients told us they felt safe when using the service. This practice was safer than other similar practices as people were protected by comprehensive systems to help keep them safe. High priority was given to ensuring the welfare and safety of patients and staff. There was a pro-active approach to anticipating and managing risks, and a focus on openness and learning when things went wrong. All staff were committed to reporting incidents and near misses. Robust systems were in place for handling and monitoring significant events and incidents. There were enough staff to keep patients safe.

The practice was commissioned to provide services to vulnerable and hard to reach patients; in view of this they had high numbers of vulnerable patients. Comprehensive systems were in place to help keep patients safe, and to manage risks to vulnerable children and adults. In addition to all staff having attended safeguarding training specific to their role, all staff were undertaking IRIS (Identification and Referral to Improve Safety) training to further their awareness, recording of disclosures and referrals of domestic violence and abuse to appropriate agencies.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Robust systems were in place in regards to managing, monitoring and improving outcomes for patients. Patients' needs were assessed and their care and treatment was delivered in line with evidence based practice. The practice had strong links and worked collaboratively with other services to ensure that patients 'received effective care and treatment. A peer review system was used for all referrals to secondary care, except for urgent ones. Two GPs reviewed the appropriateness of referrals prior to them being sent, to ensure that patients were treated appropriately. This had helped to significantly reduce referral rates to dermatology; the practice was previously the third highest referrer out of 59 local practices.

The clinical staff were pro-active in using their contact with patients to help improve their health and wellbeing, by offering opportunist screening checks. For example, 91% of women aged 25 to 65 years had received a cervical screening test in the last 5 years, which was above the national average of 74.3% and local average of 74.6%. The screening uptake had increased significantly over the last two years, following the introduction of a nurse to lead on cervical cytology and the high levels of opportunistic screening carried out when

Summary of findings

patients attended the practice. The services were effective as all staff had clear roles in monitoring and improving outcomes for patients. Staff were actively supported to acquire new skills to ensure high quality care. The practice had a highly motivated staff team with extensive knowledge, skills and experience to enable them to carry out their roles effectively.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services.

Feedback from patients and stakeholders was consistently positive about the level of care and the way staff treated people. Patients said that they were treated with kindness, dignity and respect, and were actively involved in decisions about their care and treatment. Importantly, they felt the practice offered an exceptional caring service. They received personal care from a staff team that were compassionate, supportive and non-judgemental, and who understood their needs. Data showed that patients rated the practice higher than others for almost all aspects of care. For example, the 2015 national GP patient survey showed that 89% of people said the GP gave them enough time compared to the area average of 85% and national average of 87%. Also, 94% described their overall experience of this surgery as good compared to the area average of 84% and national average of 85%.

We observed a patient-centred culture. Staff were motivated and inspired to offer compassionate care that promotes peoples' dignity. Relationships between staff and patients were very positive and supportive. Patients were respected and valued as individuals; their emotional and social needs were seen as important as their physical needs. We found many positive examples of staff going that extra mile to provide a caring service. For example, the relatives of a patient were experiencing difficulties in bringing their family member to the practice for regular tests. A practice nurse now visited the patient in their own home to carry out their tests and other health checks.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

Patients were able to access appropriate care and treatment when they needed it, and could access appointments and services in a way and at a time that suited them. The services were delivered in a way to ensure flexibility, choice and continuity of care. The staff team were highly responsive to meeting peoples' needs, and

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engaging with patients from hard to reach groups who were reluctant to attend the practice, hospital or community appointments. The practice provided a transport service to patients who struggled to attend appointments.

The practice provided a wide range of services to meet peoples' diverse needs, a number of which were additional to their contractual and performance requirements. For example, the practice had developed its own primary mental health services, which included a lead GP and two experienced mental health nurses. This enabled more people to be treated locally. Complaints were actively reviewed as to how they were managed, to ensure that lessons were learnt and acted on. An annual meeting was held to review all complaints, to ensure that appropriate learning and improvements had taken place, to improve the care for patients.

Are services well-led?

Outstanding ☆

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

The practice had a clear vision with quality and safety as its top priority, which was shared by the staff team. The culture, leadership and governance arrangements were robust and ensured the delivery of high-quality person-centred care. High standards were promoted and owned by all staff. Robust systems were in place to identify and manage risks, and to ensure the service was well managed.

The practice had a highly motivated and committed staff team to enable them to deliver well-led services. There was effective teamwork and a commitment to improving patient experiences. The practice actively sought and acted on feedback from patients. There was an open, positive and supportive culture. There were high levels of staff satisfaction and constructive engagement. The commitment to learning and the development of staffs' skills was recognised as essential to ensuring high quality care. Staff were actively supported to acquire new skills and further develop their knowledge. The practice was exceptionally well-led. The culture and leadership empowered staff to carry out lead roles, and innovative ways of working to meet patients' needs, and to drive continuous improvements.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people.

Patients were supported to remain active and help reduce the risk of falls. The practice kept a register of older people who had complex needs, or were at risk of admission to hospital. As part of the enhanced service all patients over 75 years had a named GP to provide continuity of care and were offered an annual health check. In addition, the practice allocated all patients a named nurse and healthcare assistant (HCA) to oversee their needs. The practice had 33 patients over 75 years; all patients had been offered a health check and 29 had attended this in the last 12 months. Carers were identified and supported to care for older people. Home visits were also carried out for frail and elderly patients who were unable to attend the practice.

The practice had 132 patients aged over 65 years; all patients were offered the influenza immunisation in the 2014/2015 period to reduce the risk of them developing flu, of which 80 patients received this. The practice had introduced a project to further improve the physical and psychological wellbeing of their older population. This involved allocating a named GP, practice nurse and HCA to all patients over 65 years to ensure their needs were being met. They were also offering an annual health assessment. This differed from the above enhanced service, in that the patient inclusion criteria was broader and they were allocated a nurse and a HCA as well as a GP. The practice carried out a search every eight weeks on all patients over 65 years, to establish if they had been seen or had contacted the practice in the last six week. If no contact had been made a HCA would contact them to check all was well.

People with long term conditions

Outstanding ☆

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

Patients had a named GP and nurse to provide continuity of care and ensure their needs were being met. The nurses and GPs had lead roles in the management of long-term conditions, including diabetes, asthma and heart failure having received appropriate training. The practice actively screened patients for various long-term conditions, particularly during a new patient and annual health check. Patients were offered an annual health check; the uptake for various long-term conditions was high. For example, 80% of patients with asthma, 94.5% of patients with chronic obstructive pulmonary disease and 100% of patients with rheumatoid arthritis

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had received a health review in the last 12 months. The clinical staff worked closely with specialist nursing teams to meet patients' needs. For example, they held shared care clinics with the specialist community diabetic nurse, to support patients to manage their condition effectively. Data showed that patients with primary long-term conditions such as diabetes, heart failure, stroke and respiratory disorders were engaging with the practice, as the number of emergency admissions was low compared with other local practices.

High importance was placed on educating patients to self-manage their conditions. For example, the practice had implemented a City wide initiative, which demonstrated the use of inhalers by video, and simple physiotherapy exercises for the benefit of patients with asthma and musculoskeletal conditions. The clinical team were also implementing the Diabetes Year of Care approach, which firmly puts the patient at the centre of their care and supports them to self-manage their condition. This initiative was in the early stages of development.

Families, children and young people

Outstanding ☆

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

Priority was given to appointment requests for children and young people. Children and young people were able to attend appointments outside of school and college hours. The health visitor held a weekly baby clinic at the practice. An immunisation clinic was held at the same time as the baby clinic, which enabled the staff to provide immunisations to families attending both clinics. The clinical staff also had several appointments blocked out each day, to enable them to carry out opportunist health screening and immunisations for families and children. Data showed that the immunisation rates for children under two years was 92.42% compared to the local average of 96%, the measles, mumps, and rubella rate was 90.9% compared to the local average of 91% and the pre-school booster rate was 82.9% compared to the local average of 87.52%. The rates were lower than the local average due to the high transient population and cultural issues. However, compared to previous years the immunisation rates were increasing. A robust system was in place for following up patients who did not attend their vaccine.

The practice provided maternity and family planning services, including contraceptive implants. The practice also provided sexual health services, including advice for teenagers. All patients were offered sexual health screening at the new patient check, which includes all sexually transmitted infections. Robust systems were in

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place to manage risks to children and young people, who were vulnerable or at risk of abuse. The safeguarding leads had jointly developed a child health booklet with the local safeguarding team and a local practice, which had been adopted citywide. This is an educational guide for parents to assist them to seek the most appropriate medical services.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working age people (including those recently retired and students).

Extended opening hours were provided, which include early morning, evening and weekend appointments across two locations. This enabled patients to access appointments at a time that suited them. Patients were also offered telephone consultations and were able to book appointments by telephone or on line. They also had access to 'choose and book' for patients referred to secondary services, which provided flexibility over when and where their appointment took place. The practice provided travel immunisation clinics. Sexual health screening including Human Immunodeficiency Virus **(**HIV) was also offered to all new patients at registration, due to the potential higher incidence in the City and high level of overseas registrants. The practice also worked with local employers to provide flu vaccination programmes for their staff.

NHS health checks were offered to patients aged 40 to 74 years, where patients were screened for various conditions including dementia, diabetes and heart disease, together with lifestyle advice. The uptake on health checks was low due to the practice demographic. For example, between May and June 2015 the practice sent 280 invitations and 20 patients attended. The practice continued to develop ways to encourage patients to attend the health checks. The practice had implemented further training for health care assistants to enable them to carry out robust health checks. Following the success of a national pilot for out of area registration, the practice elected to continue to register patients who live elsewhere and choose to access GP services in Nottingham. The current figure for registrations was 134.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable.

The practice had high numbers of patients who were vulnerable, homeless, patients seeking asylum, forensic patients or had multiple illnesses and social needs. The practice held a register of all patients whose circumstances may make them vulnerable. Patients

Summary of findings

had an allocated GP and nurse to ensure continuity of care. Robust systems were in place to manage risks to vulnerable patients and ensure their needs were being met. Patients had a care plan and they were reviewed at the practice's weekly clinical and monthly multi-disciplinary meetings. Patients were offered same day appointments or telephone consultations. When needed, longer appointments were available. Patients were invited to attend an annual health check. The register included 14 patients with a learning disability. The practice had involved the disability health co-ordinator to ensure they received an annual health checks. Four patients had received a health review in 2015 and the remaining reviews were planned.

There was a GP and nurse lead for safeguarding, both children and vulnerable adults. They were responsible for overseeing and co-ordinating vulnerable patients care at the practice, liaising with other services and attending multi-agency protection meetings. The staff team worked in partnership with the local homeless team and the asylum seekers and refugee forum. For example, homeless people were able to use the practice address to register. An information sharing agreement was in place with the local homeless team for sharing concerns about a patient. The practice also worked closely with the probation services to provide services for patients in three hostels through a shared care agreement.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health.

Approximately 25% of patients had poor mental health. The practice held a register of patients. All patients had a named GP and nurse to provide continuity of care. The staff team worked collaboratively with other services, to ensure that patients' needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Data showed that 95.4% of patients had a comprehensive care plan completed the last 12 months. Patients were supported to access secondary care, where appropriate. Many of the patients had complex mental health needs and required on going support by the practice. The in-house primary mental health team worked closely with the vulnerable adult lead nurse and GP to support patients. Mental health assessments could be booked by any clinician or by the patient themselves. One of the mental health nurses was a prescriber and the other was a psychotherapist, which enabled them to offer a broad range of treatments to patients. The

Summary of findings

mental health nurse prescriber saw approximately 30 patients a week for assessment, prescribing reviews and short term intervention. The psychotherapist saw approximately 20 patients a week for courses of treatment over 12 to 24 weeks.

The two GP leads for substance misuse held weekly shared care clinics, which enabled patients to be treated at the practice. The clinic held at the branch surgery was extended to non-registered patients; seven out of 27 patients attending this were not registered with the practice. At the main surgery 31 registered patients were receiving support from the clinic.

The practice had a young population; 84% of patients were under 40 years of age. At the time of the inspection, the practice did not have any patients with dementia. However, they screened patients for dementia as part of the new patients check and at the long-term conditions annual reviews to facilitate early referral and diagnosis where dementia was indicated. The unusually low incidence of dementia was due to the practice demographic.

Summary of findings

What people who use the service say

Prior to the inspection we left comment cards for patients to complete. We received 27 completed cards. We also spoke with seven patients during our inspection, and received feedback from a further four patients via a video link.

Feedback from patients was continually positive about the care and treatment they received and the way staff treat them. They described the staff as friendly and helpful, and said that they were treated with kindness, dignity and respect. Importantly, they received personal care from a staff team who were very caring, supportive and non-judgemental. Several patients referred to the staff team and the service as excellent, exceptional and 1st class. Further patients told us that their health and wellbeing had significantly improved, with the support and treatment they had received from the staff team.

Patients told us they were able to access appropriate care and treatment when they needed it. They described their experience of making an appointment as good, with urgent appointments usually available the same day. They also said that they felt listened to, and able to raise any concerns with staff if they were unhappy with their care or treatment at the service, as the staff were approachable. They found the premises welcoming, clean and accessible.

The practice had an established virtual patient representation group, which enabled a broad range of patients to have a say about the quality of care they received. A face to face Patient Participation Group (PPG) had recently formed, which included a group of patients who worked together with the practice staff to represent the interests and views of patients, so as to improve the service. We spoke with two representatives from the PPG. They told us they felt supported in their role, to represent the views of patients to improve the service.

The most recent data available for the practice on patient satisfaction included the 2015 national GP patient survey, which 74 patients completed. This showed high levels of patient satisfaction with the care and treatment they received. In almost all areas the practice's results were higher than the local and national averages. For example, 95% said that they were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 83% and the national average of 85%, and 94% described their overall experience of this surgery as good compared to the area average of 84% and national average of 85%.

We also reviewed patient reviews of the practice on NHS Choices completed in the last six months. Four positive comments referred to the standard of care and service, the approach of staff and access to appointments. One negative comment stated that it took them a month to see someone. The practice manager assured us that they had followed up this issue.

Areas for improvement

Action the service SHOULD take to improve

Develop the clinical audit programme to ensure that all audits are completed to a consistent standard to provide assurances that patients are receiving effective care and treatment.

Outstanding practice

- The practice provided a wide range of services to meet patients' diverse needs. For example, 25% of patients had poor mental health. The practice had developed its own primary mental health services, which included a lead GP and two experienced nurses. One of which was a prescriber and the other was a psychotherapist, which enabled them to offer a broad range of treatments to patients.

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- In addition, the two GP leads for substance misuse held weekly shared care clinics, which enabled patients to be treated at the practice. The clinic held at the branch surgery was extended to non-registered patients; seven out of 27 patients attending this were not registered with the practice.
- The practice had high numbers of patients who were asylum seekers. The practice was working with public health and the local charity for refugees and asylum seekers, to develop a multilingual booklet, which would enable families from overseas to understand the National Health Service.
- High importance was placed on educating patients to self-manage their conditions. For example, in conjunction with the Community Pharmacist the practice had developed videos demonstrating inhaler techniques and simple physiotherapy exercises, for the benefit of patients with asthma and musculoskeletal conditions.

NEMS Platform One Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included three specialist advisors including two GPs and a practice nurse, and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to NEMS Platform One Practice

NEMS Platform One Practice provides diverse primary medical services. It is commissioned with the aim of engaging with hard to reach groups, reducing health inequalities and improving the health of local people.

The practice opening in February 2010 with a zero patient list and now has approximately 8,500 patients, of which 84% are under 40 years of age and 25% are from black and minority ethnic population. The practice also has a high transient population and numbers of patients who were vulnerable, homeless, seeking asylum, misused substances or had poor mental health.

The practice is based in Nottingham city centre. The address where the regulated activities take place is: Station Street, Nottingham, NG2 3AJ.

The practice is managed by NEMS Healthcare Limited. The provider also manages a branch GP surgery and a walk in centre at 79A Upper Parliament Street, Nottingham NG1 6LD. In addition, the provider manages the urgent medical care and advice out out-of-hours service for Nottingham City and Nottinghamshire South Clinical Commissioning Groups. This service is registered under a separate registration. This service operates from the same location as NEMS Platform One Practice.

The practice has a large staff team, including administrative staff, a practice manager, assistant practice manager, facilities manager, a deputy and a lead nurse, two specialist mental health nurses (one of which is also a psychotherapist), a consultant nurse practitioner, five practice nurses, four health care assistants, seven salaried and two locum GPs. Various staff work across the two practices.

There are 4.28 whole time equivalent GPs working at the practice, in addition there are 6.9 whole time equivalent nursing staff.

It is a training practice for medical students and nurses.

The practice had one patient list, which means that patients can access the services at the main practice and the branch surgery. The practice opening hours are Monday 8am-7pm, Tuesday 7.30am-6.30pm, Wednesday 8am-7pm, Thursday 8am-6.30pm & Friday 7.30am-6.30pm.

The branch surgery is open from 9am-7pm Monday to Friday. Pre-bookable appointments are also available from 9am-1pm on Saturday and Sunday; in addition, to a small number of urgent appointments. Patients can also access the walk in centre from 9am -7pm every day of the year, which is located at the same site as the branch surgery.

The practice holds an Alternative Personalised Medical Services (APMS) contract to deliver essential and some additional enhanced primary care services. The contract means only salaried GPs are employed and there are no partners.

Detailed findings

The practice does not provide out-of-hours services to the patients registered there. These services are provided by NEMS Community Benefit Services Limited. Contact is via the NHS 111 telephone number.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

Older people

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

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. We also obtained feedback from three external organisations and agencies, who worked closely with the practice. We carried out an announced visit on 30 June 2015 to the main practice and the branch surgery.

During our visit we checked the premises and the practice's records. We spoke with various staff including the lead nurse, deputy lead nurse, a practice nurse, a health care assistant, consultant nurse practitioner, four GPs, the facilities and project manager, reception and administrative staff, practice manager and deputy manager. We also received comment cards we had left for patients to complete, and spoke with patients and representatives who used the service.

Good

Are services safe?

Our findings

Safe track record

Patients told us they felt safe when using the service.

Records showed that safety incidents and concerns were appropriately dealt with. The practice used various information to identify risks and improve patient safety, including reported incidents and national patient safety alerts as well as comments and complaints received from patients to identify risks and improve patient safety.

A system was in place to ensure that staff was aware of relevant patient safety alerts and issues, and where action needed to be taken.

Staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, staff had highlighted a cold chain failure; a vaccine delivery had not been promptly placed in the refrigerator. Relevant advice was sought; in view of an element of risk to patients the vaccine was destroyed. Following the incident, a new policy and improved systems were put in place to minimise further incidents.

We reviewed incident reports and safety records for the last two years. This showed the practice had managed these consistently over time, and so could show evidence of a safe track record over the long term.

Priority was given to ensuring the safety of patients and staff. There was a pro-active approach to anticipating and managing risks. The practice had a number of patients whose behaviour was unpredictable due to health issues, or who had a history of violence. We saw that risks to patients and staff were assessed and appropriately managed. There had been no incidents where anyone had been harmed at the practice which indicated that these systems and measures were fully implemented and effective in practice.

Learning and improvement from safety incidents

Staff told us that the practice was open and transparent when things went wrong. We found that the practice had a robust system in place for reporting, recording and monitoring significant events, incidents and accidents.

We received the records of significant events that had occurred during the last two years. Minutes of meetings showed that these were discussed at weekly clinical meetings. An annual meeting was also held to review actions from significant events to promote learning and improvement, which all GPs, lead nurses, practice manager and assistant practice manager attended.

There was evidence that the practice had learned from incidents, and that the findings were shared with relevant staff. For example, two separate incidents involving incorrect smear procedures were reviewed with the clinical staff. Following the incidents, the policies were updated and additional training was provided to update staff's knowledge.

Reliable safety systems and processes including safeguarding

Comprehensive systems were in place to manage and review risks to vulnerable children, young people and adults. The practice had a high number of vulnerable patients, including 323 children. There was a pro-active approach to protecting patients from abuse and avoidable harm.

An alert system was in place to highlight vulnerable patients on the practice's electronic records, including children subject to child protection plans. The system ensured that they were clearly identified and reviewed, and that staff were aware of any relevant issues when patients contacted the practice or attended appointments.

All staff we spoke with said that they had received recent safeguarding training specific to their role. Records supported this. All 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, record safeguarding concerns and how to contact the relevant agencies. Contact details were accessible.

One of the GPs and a nurse lead in safeguarding adults and children, and worked closely with the local safeguarding team. One of the nurses was also responsible for overseeing vulnerable patients, specifically the homeless, asylum seekers and those living at probation hostels. The safeguarding leads could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the leads were, and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

The safeguarding leads were aware of vulnerable children and adults registered with the practice, and demonstrated good liaison with partner agencies such as the police, social services and organisations specialising in domestic violence and abuse (DVA). For example, a patient had expressed concerns to staff about their safety. The staff team alerted relevant agencies that the patient had not visited the surgery for some time. Appropriate action was taken to secure the safety of the person.

In addition to all staff having attended safeguarding training specific to their role, all staff were undertaking IRIS (Identification and Referral to Improve Safety) training on domestic violence and abuse, to further their awareness, recording of disclosures and referral of domestic violence to appropriate agencies.

Records showed that relevant professionals and partner agencies shared information about vulnerable children and adults, to help protect them from avoidable harm. For example, the lead GP and nurse for safeguarding children, health visitor and midwife meet each month to share information, discuss safeguarding issues and best ways to support the families. Monthly multi-disciplinary meetings were also held, to share information about vulnerable adults.

A chaperone policy was available, which was visible to patients at the surgery and on the practice website. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

Discussions with staff and records showed that staff who acted as chaperones had undertaken relevant training. They had also had a satisfactory disclosure and barring (DBS) check. A DBS check helps prevent unsuitable staff from working with vulnerable people, including children.

Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Several patients told us that the system in place for obtaining repeat prescriptions worked well to enable them to obtain further supplies of medicines.

Procedures were in place to protect patients against the risks associated with the unsafe use of medicines. For example, regular checks were carried out to ensure that medicines including vaccines were within their expiry date and suitable for use. An electronic data logger recorded the temperature of the vaccine refrigerators, which staff monitored. Staff also manually checked the temperatures each day as a further assurance the medicines were kept at the required temperatures.

The nurses and health care assistants administered vaccines using patient group directives that had been produced in line with national guidance. We saw evidence that they had received appropriate training to administer vaccines.

Expired and unwanted medicines were disposed of in line with waste regulations. All medicines we checked were stored securely, managed appropriately and were only accessible to authorised staff.

All prescriptions were checked 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.

A system was in place to oversee the management of high risk medicines, which included regular monitoring in line with national guidance. The practice worked with the Clinical Commissioning Group (CCG) medicines team, to ensure that medicines were managed safely. The medicines team carried out regular audits, to check that patients' medicines were prescribed appropriately.

Cleanliness and infection control

We observed the premises to be clean and tidy. Cleaning schedules were in place and records were kept to ensure that the practice was hygienic. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to and personal protective equipment including disposable gloves, aprons and spillage kits were available for staff to use to comply with the policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

One of the nurses was the lead for infection control; they demonstrated that they had the necessary training to

enable them to fulfil this role. Staff we spoke with told us they received training on infection control on induction and regular updates. Records showed that staff had attended recent training.

The facilities and project manager was responsible for overseeing the cleaning contract provided by an external provider. He attended monthly meetings with the cleaning provider to review the contract and standards of cleanliness. We saw records to support this.

The facilities and project manager told us that the cleaning provider also carried out regular audits to monitor the standard of cleanliness, and ensure that appropriate practices were being followed. The practice did not see the reports. They agreed to request a copy of these, to provide further assurances as to the standard of cleanliness and infection control.

We saw that an external provider (not linked to the cleaning provider) had completed a comprehensive infection control audit in October 2014 and prior to this in September 2012. A further audit was completed in April 2015 to check if improvements identified for action from the last audit had been completed. The audit recorded an overall score of 94%, compared to the previous audit score of 86%. The findings and remedial actions were shared with the staff team, and an action plan had been put in place to achieve full compliance.

The practice had a policy for the management and testing of legionella (bacteria. Records we looked at supported that the practice was carrying out regular checks, in line with their policy and risk assessment to reduce the risk of infection to staff and patients.

A practice also had a policy relating to the immunisation of staff, including the risk of exposure to Hepatitis B infection, which could be acquired through their work. The new lead for infection control had identified that the immunisation records were not up-to-date; to show that all relevant staff were protected from relevant infections including Hepatitis B. The practice manager and lead nurse assured us that they were updating the records to provide evidence of this.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We checked various stock supplies of clinical and medical items including dressings and equipment used for minor surgery; all items were in date and sealed. Records showed that relevant staff checked all supplies at regular intervals to ensure they remained in date and appropriate to use.

All equipment was tested and maintained regularly and a schedule of testing was in place. We saw evidence that relevant equipment was calibrated at the required intervals; this included the weighing scales, blood pressure measuring devices and the defibrillator (used to attempt to restart a person's heart in an emergency).

Staffing and recruitment

The practice had a recruitment policy. We found that robust recruitment procedures were followed in practice to ensure that new staff were suitable to carry out the work they were employed to do.

The provider obtained an enhanced disclosure and barring (DBS) check for all new staff as part of its recruitment checks. The personal team kept evidence of this. A DBS check helps prevent unsuitable staff from working with vulnerable people. The practice manager received confirmation that a DBS check had been obtained, prior to new staff taking up post.

We checked the files of four staff that had been employed in the last six months. The records showed that appropriate recruitment checks had been undertaken, including the information required by law to ensure that staff were suitable to work with vulnerable adults and children.

A policy for checking nurses' and GPs' qualifications and registration to practice was in place. Records showed that the practice manager carried out appropriate checks, to ensure that the nurses and the GPs remained registered to practice with their relevant professional bodies.

A rota system was in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for staff to cover each other's annual leave and absences, where possible.

The patient list has continued to steadily increase each month since the service opened in 2010, which required a pro-active approach to the planning and monitoring of the skill mix and numbers of staff needed. We saw evidence of this.

Good

Are services safe?

The practice had a large staff team, which has continued to increase in size and skill mix to meet patients' needs and the expansion of the service. Various staff had worked at the practice since it opened in February 2010, which ensured continuity of care and services.

The practice manager confirmed that three new GPs had been appointed in the last 12 months, although one had recently left. Two locum GPs currently provided support to the clinical team.

To meet the demands on the service, a further three GPs had recently been appointed who were due to take up post. This will provide a further 12 GP sessions a week. Once the newly appointed staff are established the use of locum GPs would not be required. The demands on the reception staff were high. In response to feedback from staff, the practice had appointed a further whole time equivalent post to support the reception team.

Monitoring safety and responding to risk

The practice had systems and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, equipment, medicines management, staffing and dealing with emergencies. Records showed that essential health

and safety checks were carried out. For example, the lift and fire alarm system were regularly serviced to ensure they worked properly.

We saw that the practice had completed various health and safety risk assessments, including actions required to reduce and manage risks.

The facilities and project manager was the health and safety lead, and oversaw all aspects of safety within the practice.

All staff collected a personal alarm at the start of each shift, if this was activated it gave the location of the member of staff at several central control panels. All clinical areas were accessed through key fob controlled entry doors and release button exits. The arrangements in place gave a high level of security and safety for patients and staff, which were unobtrusive.

Staff were able to identify and respond to risks to patients including deterioration in their well-being. For example, procedures were in place to deal with patients that experienced a sudden deterioration in health, and for identifying acutely ill children to ensure they were seen urgently. Arrangements were also in place for patients experiencing a mental health crisis, to enable them to access urgent care and treatment. The practice monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we looked at showed that staff had received recent training in basic life support.

Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines and equipment were not kept in a secure area of the practice during opening times or overnight. They were therefore accessible to people visiting the practice and the cleaning staff. Senior managers had identified and were addressing this issue. At the end of the inspection we received assurances that the emergency medicines and relevant equipment would be stored in a secure area, which was accessible for emergency use. The area was only accessible to practice staff.

The emergency medicines included those for the treatment of common cardiac conditions, anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). It also included other suggested essential medicines GP practices should hold in line with local guidance.

Processes were 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 comprehensive business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Actions were recorded to reduce and manage the various risks. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

Good

Are services safe?

A fire risk assessment had been carried out, which included actions required to maintain fire safety. Records also showed that staff had received recent fire training, or were due to complete this. As part of the training, all staff were required to practice an annual fire drill, to ensure they knew what to do in the event of a fire.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients told us they received effective care and treatment.

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Staff told us that they discussed new guidelines and agreed changes to practice at team meetings. We saw evidence of this.

The practice knew the needs of their patient population well. There was a holistic and pro-active approach to meeting patients' needs, which was driven by all staff at the practice. Innovative approaches were used to support the delivery of high quality care. The GPs and nurses were able to demonstrate that they had oversight and a good understanding of best treatment for each patient's needs

GPs and nurses completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed, together with the effectiveness of their care and treatment.

Management, monitoring and improving outcomes for people

The services were effective as all staff had clear roles in monitoring and improving outcomes for patients resulting in a practice wide approach to care and treatment. The GPs and nurses had lead roles in clinical areas such as diabetes, asthma, dermatology, substance misuse and mental health. This enabled them to focus on specific conditions and improve outcomes for patients.

The clinical team made use of a peer review system for all referrals to secondary care, except for urgent ones. This involved two GPs reviewing the appropriateness of referrals prior to them being sent.

Prior to the recruitment of a GP with specific skills and interest the practice was previously the third highest referrer to dermatology secondary care in the Nottingham City. The practice now had an internal referral service to the specialist GP and the referral rate was considerably lower; the current ranking was 32 out of 59. A recent audit of GP referrals had been completed, which highlighted only two that could have been managed at the practice.

The practice had the third highest emergency admission rates for the locality in regards to conditions, which are considered to be preventable in some cases, including dental, ear, nose and throat, epilepsy and pyelonephritis (inflammation of the kidney as a result of infection). The practice had explored the reasons for these admissions, which they had shared with the Clinical Commissioning Group. No significant issues were found and the admissions were considered appropriate.

Clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). For example, the practice's prescribing budget for vitamin D was higher than other local practices. An audit was completed in response to this. This showed that the practice was pro-active in screening patients for vitamin D deficiency, specifically in view of the high numbers of patients from overseas. The practice also had to pay a higher cost for a vitamin supplement, which was acceptable to certain cultures. The audit maintained that patients were receiving effective treatment.

The practice had completed various audits in the last two years, which were used to improve the outcomes for patients. We looked at three completed audits which demonstrated the changes made resulting from these. For example, an audit was completed in response to an incident involving the fitting of an intra-uterine device. This showed that appropriate clinical practice had been followed. However, a change was made to the recording template on the clinical system, to provide further evidence that the procedures were in line with best practice.

Three further clinical audits we looked at did not follow a formal protocol and were not documented to a consistent standard, to demonstrate the outcomes being achieved and any areas for improvement. The GPs agreed to review this. Records showed that the GPs and nursing team attended weekly clinical meetings. These enabled the staff to discuss clinical issues and peer review each other's practice, driving improvements in care.

We saw that patients were asked to complete a clinical outcome questionnaire, which was used to evaluate the effectiveness of psychotherapy. For the last 32 patients seen the average score at the first psychotherapy session

was 68.8 and the average score at the last session was 28.5. This showed that patients' symptoms on average had improved by over 50%. This was in line with recovery rates in other psychological services.

The quality and outcomes framework (QOF) performance data for 2013 to 2014 showed that the practice achieved a total of 92.3% in respect of their performance in measuring national clinical indicators, which was 0.3% above the local and 1% below the national average. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for applying preventative measures. The practice performance was above the national and local average in 15 out of the 20 clinical areas assessed.

There were several QOF areas where full points were not achieved, because there were no patients in that particular indicator, for example dementia. The QOF data was discussed at team meetings. We saw that the practice had put robust action plans in place to bring about the necessary improvements, where required.

Effective staffing

The practice had a highly motivated staff team with extensive knowledge, skills and experience to enable them to carry out their roles effectively. Staff worked well together as a team.

The staff team continued to increase in size and skill mix to meet patients' needs and the growth of the service. Above all, the skill mix and numbers of whole time equivalent nursing staff had increased significantly, as nurses had taken on additional roles to support the GPs and the expansion of the services. The development of nurse prescribers had also allowed for more holistic nurse-led patient care.

High importance was given to the continuing development of staff skills, competence and knowledge. All staff we spoke with praised the level of training, personal development and support they received. They were actively supported to acquire new skills, to ensure the delivery of high quality care. For example, the health care assistants were due to attend training on pneumonia vaccinations and spirometry (lung function tests), to develop their skills and undertake such roles.

Records showed that staff had attended appropriate training to meet patients' needs. Staff were up to date, and had attended refresher courses such as safeguarding, infection control and emergency life support. Further training needs had been identified and planned. Clinical staff told us they received protected learning time. They also received allocated time to complete clinical records, and discuss and reflect on patients care and treatment with other clinicians.

Staff assured us that they had received appropriate induction training and support to enable them to carry out their work. We spoke with two new reception staff who had/were undertaking a two week induction. They said they felt that they had/were receiving appropriate induction and support to carry out their role. We saw that an information handbook containing useful information was available to reception staff.

The practice manager informed us that reception staff usually received a two week induction, whilst other staff received an induction appropriate to their experience and skills. We saw that staff completed a generic induction programme that was not specific to staff roles, to assist them to carry out their work. The practice manager acknowledged the need to update this.

Staff told us that they received supervision through peer support and meetings they attended. They also received an annual appraisal to review their performance and learning and development needs. A robust appraisal system was in place, which set out staff's learning needs.

The nurses performed specific duties and extended roles. They told us they had attended appropriate training to carry out these roles. For example, administrating vaccines, cervical cytology and managing patients with long-term conditions such as asthma, diabetes and coronary heart disease. Records we looked at supported this.

The health care assistants (HCA) had also received training to carry out specific roles including ear syringing and flu vaccinations. They told us they were observed undertaking the procedures to ensure they were competent to carry out the tasks. We saw that completed records to support this.

We were assured that all GPs were up to date with their yearly continuing professional development requirements, and had either 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).

The practice was a training practice for medical students and nurses. One of the GPs was the lead for clinical education and medical student teaching.

Working with colleagues and other services

The practice had strong links and worked collaboratively with other services to meet patients' needs, and support vulnerable individuals. For example, the practice worked closely with local hospitals in helping to reduce the number of patients who did not attend outpatient appointments, or who attended A & E inappropriately.

The practice had high levels of avoidable A & E attendances compared to other local practices. This was mostly due to a number of patients with chaotic lifestyles who frequently attended the service**.** The practice had a lead nurse who reviewed all inappropriate attendances. If a patient attended A & E for no apparent reason a practice nurse contacted them to discuss why they had attended, and directed them to the most appropriate service.

Staff also contacted patients with poor mental health following A&E attendances, to check all was well in regards to their welfare. We saw a recent letter from staff at Nottingham A & E department praising the work of the practice, in regards to a patient who had changed from someone who frequently attended the department to having only presented once in the last six months.

The practice also worked closely with a designated community matron and care co-ordinator, whose roles were beneficial in supporting integrated care and providing a direct point of contact. The practice held monthly multidisciplinary team meetings to discuss the needs of patients with complex needs, including those at risk of harm or un-planned admission to hospital.

Decisions about patients' needs were documented in a shared care record. Increasingly other agencies were able to add to patients electronic records; with patients consent the information was shared.

Information sharing

The practice received test results, letters and discharge summaries from the local hospital and the out-of-hours services both electronically and by post. The practice had a system for ensuring staff acted 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. Robust arrangements were in place to follow up patients discharged from hospital.

There was a shared system with the 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.

The practice was signed up to the electronic Summary Care Record (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 staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. 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

Patients told us that they were involved in decisions and had agreed to their care and treatment. They also said that they had the opportunity to ask questions and felt listened to.

Staff told us that they obtained informal consent from patients before they provided care or treatment. There was also a policy for obtaining written consent for specific interventions such as minor surgical procedures, together with a record of the benefits and possible risks and complications of the treatment. We saw evidence that written consent had been obtained, where required.

Staff gave examples of how a patient's best interests were taken into account if a patient lacked capacity to make a decision. For example, patients with learning disabilities were supported to make decisions through the use of care plans, with their involvement. Clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to

help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Clinical staff were aware of the Mental Capacity Act 2005 and their responsibilities to act in accordance with legal requirements. They said that they had received relevant training to ensure they understood the key parts of the legislation, and how they applied this in their practice. We saw records to support this.

Health promotion and prevention

We saw that a wide range of health promotion information was available to patients and carers on the practice's website, and the noticeboards in the waiting area. It was policy for new patients registering with the practice to be offered a health check. The new patients' health check had been extended to include further checks such as dementia screening. The GP was informed of any health concerns and these were followed up in a timely way.

A weighing machine was available in the reception area to enable patients to check their weight.

The practice had a high number of families from overseas. Following registration, the nursing team contacted the families to invite them to discuss the national immunisation programme and provide them with an introduction to NHS health services.

The clinical staff were pro-active in using their contact with patients to help improve their health and wellbeing, by offering various screening checks. For example, all patients were offered sexual health screening at the new patient check, which includes all sexually transmitted infections. Just over 1,400 patients registered in the past 12 months and all were offered sexual health screening, of these 549 patients were screened for blood-borne viruses that some people carry and can be spread from a person. Staff also offered opportunistic chlamydia screening to patients of relevant age.

A spirometry (lung function test) was offered to all patients aged 35 years and over who were smokers, including smoking cessation advice and support. In the last six months 66 patients had had a spirometry test.

Staff were proactive in supporting patients to manage their health needs and live healthier lives. High importance was placed on educating patients to self-manage their conditions. In conjunction with the Community Pharmacist, the practice had developed videos demonstrating inhaler techniques and simple physiotherapy exercises for the benefit of patients with asthma and musculoskeletal problems.

Staff also worked closely with and referred patients to educational programmes such as Juggle, which helps patients to understand diabetes and supports them to make lifestyle changes that will benefit their health.

The clinical team were also implementing the Diabetes Year of Care approach, which firmly puts the patient at the centre of their care and supports them to self-manage their condition. This initiative was in the early stages of development.

The practice also offered NHS Health Checks to all patients aged 40 to 74 years, where patients were screened for various conditions including dementia, stroke, diabetes and heart and kidney disease, together with lifestyle advice.

The uptake on health checks was low due to the patient demographics. Between May and June 2015 the practice sent 280 invitations and 20 patients attended. The practice continued to develop ways to encourage patients to attend. The nurse consultant had recently reviewed the protocol for the invitation to patients and the actual screening offered, and had implemented further in-house and external training for health care assistants to enable them to carry out the checks effectively. Following the recent training, clinics offering health checks had been set up, with a view to increasing the numbers of patients attending. A health care assistant was being supervised to carry out the checks.

The practice was involved in a wide range of screening programmes including bowel, breast and cervical screening. The practice's data showed that 90.2% of women aged 25 to 65 years had received a cervical screening test in the last five years, which was above the national average of 74.3% and local average of 74.6%. The screening rates had increased significantly over recent years, following the introduction of a nurse to lead on cervical cytology and the high levels of opportunistic screening undertaken when patients attended the practice to see another clinician.

Breast and bowel screening rates were below the national and local average. Data showed that 54% of females aged 50-70 years had been screened for breast cancer in last 36 months compared to the local average of 70.4% and the

national average of 72.2%. Also, 42.4% of persons, 60-69, had received screening for bowel cancer in last 30 months compared to the local average 53.8% and the national average of 58.3%. The practice had identified that the low screening uptakes were due to the high transient population, cultural issues and high numbers of patients with chaotic lifestyles.

The practice had dedicated nurses who were contacting patients who did not attend for their bowel or breast screening, to establish the reasons for this and encourage them to attend. The practice was also engaging with public health and minority ethnic and hard to reach groups, to educate them about the importance of attending the screening checks.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with national guidance. The latest data showed that the immunisation rates for children under two years was 92.42% compared to the local average of 96%, the measles, mumps, and rubella rate was 90.9% compared to the local average of 91% and the pre-school booster rate was 82.9% compared to the local average of 87.52%. Uptake figures for vaccines and immunisations were increasing compared to previous years. A robust system was now in place for following up patients who did not attend their vaccine. A pictorial display about the various immunisations was displayed in the waiting area.

Flu, pneumococcal and shingles immunisations were offered to older patients. The practice had 132 patients aged 65 years; data showed that 80 patients had received an influenza immunisation in the 2014/2015 period to reduce the risk of them developing flu. Records showed that all patients were offered the vaccine; 27 patients had refused this, and the remaining patients either did not attend or did not respond to the invitation.

The practice had a young population, 84% of patients were under 40 years of age. At the time of the inspection, the practice did not have any patients with dementia. However, they screened patients for dementia as part of the new patient check and when seeing patients check for long-term conditions reviews, to facilitate early referral and diagnosis where dementia was indicated. This unusually low incidence of dementia was due to the practice demographic.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from patients was consistently positive about the care and the way staff treat them. They described the staff as friendly, helpful and caring, and said that they were treated with kindness, dignity and respect. They also said that they felt listened to. Importantly, patients said they felt the practice offered an exceptional caring service. They received personal care from a staff team that were compassionate, supportive and non-judgemental, and who understood their needs.

We received feedback from several patients whose circumstances made them vulnerable. They told us that they were able to access the practice without fear or prejudice, and they were treated in a sensitive manner. For example, a patient who had previously been in prison a number of years had been made to feel at ease and welcome. Also, a person who misused substances appreciated the fact that the staff always treated them with courtesy, and as any other patient.

We found many positive examples to demonstrate how patient's choices and needs were valued and acted on, and staff going that extra mile to provide a caring service. For example, the relatives of an elderly patient were experiencing difficulties in bringing their family member into the practice for regular tests. Following approval, a practice nurse now visited the patient in their own home to undertake their tests and other health checks. The patient was very happy with this outcome.

We also saw a significant number of letters and emails from patients and external organisations that had been sent to the practice, praising the level of care, understanding and the approach of the staff team especially, with vulnerable and hard to reach groups.

We spoke with three external professionals/ representatives of organisations that worked closely with the practice. They told us that they felt that the staff team were very caring and treated patients with respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We observed this during our visit. We also observed that patients were treated with dignity, respect and kindness during interactions with staff. Staff were motivated and inspired to offer compassionate care that promotes peoples' dignity. Relationships between staff and patients were very positive and supportive.

The reception area had been designed to engage with hard to reach groups, and enable patients' direct contact with the staff. It had also been designed to maintain confidentiality. We observed that the reception staff were discreet and maintained patients' privacy and confidentiality. Various telephone calls were taken at the reception desk; these could not be overheard.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2015 national patient survey, which 85 patients completed. It also included returned satisfaction surveys, which the practice had sent out to patients between April and December 2014. The evidence from these sources showed that patients rated the practice higher than others for almost all aspects of care. For example, data from the national patient survey showed:

- 97% said that they found the receptionists at this surgery helpful compared to the CCG average of 87% and national average of 87%.
- 87% said the GP was good at listening to them compared to the CCG average of 86% and national average of 87%.
- 89% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 94% said they had confidence and trust in the last nurse they saw compared to the CCG average of 91% and national average of 91%
- 94% described their overall experience of this surgery as good compared to the area average of 84% and national average of 85%.

Care planning and involvement in decisions about care and treatment

Patients we received feedback from told us they were actively involved in making decisions about their care and treatment, and that their views and wishes were respected. They were given sufficient time and information during consultations to enable them to make informed choices.

Outstanding ☆

Are services caring?

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%.
- 94% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.

The practice was signed up to the enhanced service to help avoid unplanned admissions to hospital. Enhanced services are additional services provided by GPs to meet the needs of their patients.

Clinical staff assured us that all patients assessed at high risk of being admitted to hospital, including certain elderly patients and people with complex needs or in vulnerable circumstances, had a care plan in place to help avoid this. Patients care plans included their wishes, and where appropriate decisions about resuscitation and where they wished to receive end of life care. This information was available to the out-of-hours service, ambulance staff and local hospitals.

Patient/carer support to cope emotionally with care and treatment

Patients were respected and valued as individuals; their emotional and social needs were seen as important as their physical needs.

The survey information we reviewed showed that patients were positive about the emotional support provided by the practice and rated it well in this area. Patients we spoke with during the inspection and comment cards we received were also consistent with the survey information. Patients said that they were supported to cope emotionally with their health needs.

Notices in the patient waiting room and information on the practice website also told patients how to access a number of support groups and organisations, to ensure they understood the various avenues of support available to them. The practice's computer system alerted staff if a patient was also a carer.

Staff we spoke with demonstrated that importance was given to supporting carers to care for relatives, including patients receiving end of life care. Bereaved carers known to the practice were supported by way of a personal visit or phone call from their usual GP or nurse, to determine whether they needed any practical or emotional support.

Staff also told us that the practice was supportive around their work life balance, especially if they had health issues, or were carers for family members. The practice had adapted working practices for various staff. The staff team were also supportive to staff who had had a bereavement.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us that they were able to access appropriate care and treatment when they needed it. Several patients also said that their health and wellbeing had significantly improved, with the support and treatment they received from the staff team. For example, the staff had helped patients to stop drinking, smoking and taking drugs.

We found that the services were tailored to meet the needs of the local population and were delivered in a way to ensure flexibility, choice and continuity of care. There was a strong patient centred culture, and a holistic approach to meeting individual needs.

High numbers of patients from hard to reach groups were registered with the practice. The practice was proactive in engaging with patients who were reluctant to attend the surgery, hospital appointments or community clinics. For example, they worked with support workers to facilitate patient's attendance, they had flexible systems for homeless patients or those living in caravans, tents or boats, to collect prescriptions, letters or details or hospital appointments from the surgery. They also had a flexible approach if patients were late for appointments because of their chaotic lifestyles; they would be seen and attended to.

Effective systems were in place for identifying patients who needed additional support, and the practice was proactive in offering this. For example, the practice kept a register of all patients with a learning disability, experiencing poor mental health, those in vulnerable circumstances, with long-term conditions and older people.

The practice provided a wide range of services to meet peoples' diverse needs, and enable more people to be treated locally. A number of services were additional to the practice's contractual and performance requirements. For example, 25% of patients had poor mental health, many of whom had complex needs. To meet their needs, the practice had developed its own primary mental health services, which included a lead GP and two experienced mental health nurses. One of the nurses was a prescriber and the other was a psychotherapist, which enabled them to offer a broad range of treatments to patients at the practice.

The mental health nurse prescriber saw approximately 30 patients a week for assessment, prescribing reviews and short term intervention. The psychotherapist saw approximately 20 patients a week for courses of treatment over 12 to 24 weeks, and some patients for assessment.

Mental health assessments could be booked by any clinician or by the patient themselves. Appointment times of up to an hour were available, to enable one of the specialist nurse's to carry out a detailed assessment of patients' needs. This was also used as a second opinion to a GPs assessment, which helped to ensure that patients were signposted to the appropriate service.

The lead GP told us that many of their patients with complex mental health needs required on going support by the practice. They may have been discharged by secondary care or deemed not appropriate for referral, or struggled to engage with other services. The in-house primary mental health team worked closely with the vulnerable adult lead nurse and GP to support these patients.

The staff team were committed to improving the health and welfare of vulnerable patients and hard to reach groups. For example, the practice had 343 patients who misused substances. The two GP leads for substance misuse held weekly shared care clinics, which enabled patients to be treated locally.

The substance misuse clinic held at the branch surgery was extended to non-registered patients; seven out of 27 patients attending this were not registered with the practice. The practice worked pro-actively with other services, to support patients and their families, and was helping to change perceptions about people who misused substances.

Tackling inequity and promoting equality

Staff informed us they operated an open list culture. The surgery had taken part in a national pilot for out of area registration involving a small number of practices, which resulted in approximately 200 patients registering who lived outside the practice boundary.

Following the success of the above pilot, Patient Choices has been rolled out nationally, and the practice elected to continue to register patients who live elsewhere and choose to access GP services in Nottingham. The current

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

figure for registrations was 134. The practice also extended its original boundary from the City of Nottingham to include part of neighbouring county boroughs due to patient demand.

The service was commissioned to engage with hard to reach groups, reduce health inequalities and improve the health of local people. The staff team were fully committed to this. The practice had a high number of patients who were vulnerable, homeless, asylum seekers, forensic patients, had poor mental health or misused substances. Several patients we received comments from appreciated the fact that the staff team were supportive, non-judgemental and treated them as any other patient.

The practice received excellent feedback from the local charity for refugees and asylum seekers, in respect of the high numbers of patients who had registered with the practice and the care they received. The practice was working with public health and the above forum to develop a multilingual booklet, which will enable overseas families to understand the National Health Service.

We were given various examples of high numbers of patients from hard to reach groups having registered with the practice, some of which had not previously been registered with a GP. For example, 275 patients were homeless. They were able to use the practice address to register. The practice worked closely with the local homeless team. An information sharing agreement was in place for sharing concerns about a patient. If the practice needed to see a patient they would ask the team to get in touch with the patient and contact the surgery.

The practice provided primary medical services to 229 patients residing at hostels. The practice worked closely with probation services to provide care for patients through a shared care agreement. This included patients residing in two probation hostels in the City, which accept high risk prisoners on licence. A protocol covering areas such as consent and information sharing, prescribing, curfews, safety alerts and multi-agency protection arrangements was in place. Many patients continued to be registered when they were released.

The practice was also approached by NHS England area team to take on patients from an out of area rehabilitation unit. The practice worked closely with the management team at the unit to provide services for this particularly vulnerable group of patients, who often have complex physical and mental health needs as a result of their previous lifestyles. In view of the distance from the surgery, patients residing at the out of area unit attended the practice by various forms of transport.

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

Staff told us that several appointments were held each day, to accommodate urgent requests from patients who had chaotic lifestyles, and struggled to cope with an appointment system. This included patients who misused substances, were homeless, vulnerable, and experienced poor mental health. We saw that appointments were set aside during our inspection.

There were two male locum GPs and seven female GPs working at the practice. The practice had recently recruited another male GP, to enable patients' further choice to see a male doctor.

We saw that patients and staff had access to interpreters, online and telephone translation services if they were needed. Staff were aware of when a patient may require an advocate to support them, and there was information on advocacy services available for patients.

The practice population was very diverse, including a high number of Asian, Arab, Polish and Chinese patients. There were a considerable number of patients who did not have English as their first language. Staff we spoke with were able to describe a good awareness of culture and ethnicity issues. They were also aware of how to use language line, and how to book an interpreter where necessary. They also told us they had completed equality and diversity training, and that equality issues were discussed at 1 to 1's and meetings. Records supported this.

The premises and services had been designed to meet the needs of people with disabilities, and were accessible to patients. The services for patients were located on the ground and first floor. The premises were spacious and included an appropriate lift to the first floor. There was also access to disabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and pushchairs. This made movement around the practice easier and helped to maintain patients' independence.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients told us that they were able to access the service, and appropriate care and treatment when they needed it. They described their experience of access to the service and appointments as good, with urgent appointments usually available the same day.

Patients were able to book an appointment in person, by telephone or on line at the main practice and the branch surgery. They were also able to request a repeat prescription on line or in writing. The practice also provided a text message reminder for appointments. Patients could also cancel appointments through this service. Patients could obtain test results by phone or via email to the practice.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments, and rated the practice highly in these areas. For example, the 2015 GP patient survey showed that:

- 91% of people surveyed, were able to get an appointment to see or speak to a clinician the last time they tried, compared to the CCG average of 83% and national average of 85%.
- 90% said that they found it easy to get through to the practice by phone, compared to the CCG average of 75% and national average of 73%.
- 91% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 91% described their experience of making an appointment as good, compared to the CCG average of 73% and national average of 73%.
- 68 % said they usually waited 15 minutes or less after their appointment time, compared to the CCG average of 62% and national average of 65%.

The practice had a robust triage and appointment system which enabled patients to access the right care at the time.

The practice had one patient list, which meant that patients could access the services at the main practice and the branch surgery. The practice opening hours were: Monday 8am-7pm, Tuesday 7.30am-6.30pm, Wednesday 8am-7pm, Thursday 8am-6.30pm & Friday 7.30am-6.30pm.

The branch surgery was open from 9am-7pm Monday to Friday. Pre-bookable appointments were also available from 9am-1pm on Saturday and Sunday; in addition, to a small number of urgent appointments.

Patients could also access the walk in centre, which was located in the same building as the branch surgery. This service was open from 9am to 7pm every day of the year. Access to the service and the opening hours enabled children and young people to attend appointments after school and college hours. It also enabled patients who had chaotic lifestyles, working age patients and those unable to attend during the day, to attend at weekend or in the evening.

Discussions with staff and records showed that the appointment system and telephone response times were regularly reviewed, to ensure that the practice responded to patients' needs.

We found that the appointment system was flexible to meet the needs of patients. Longer appointments were available, where required. Staff offered patients a choice of appointments to meet their needs, where possible. Pre-bookable appointments were available four weeks in advance. Systems were in place to prioritise urgent and home visit appointments, or phone consultations for patients.

The practice provided a transport service to patients who had difficulty in accessing the practice, or struggled to attend appointments. This included a designated taxi service. The practice paid the transport costs.

An on call GP and a triage nurse were available during the week; all doctors and nurses were on the roster. Patients requiring urgent attention were initially assessed by the on call GP or a nurse**,** to enable them to direct the patient to the most appropriate clinician and services. If a patient was booked in with a nurse and a GP opinion was then required, the on call GP was available.

Information about the appointment system, opening times and the out-of-hours service was available in the reception area and on the practice's website. If patients called the practice when it was closed, an answer phone message gave the telephone number they should ring depending on the circumstances.

Listening and learning from concerns and complaints

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Patients said they felt listened to and were able to raise concerns about the practice as the staff were approachable. Certain patients were not aware of the process to follow should they wish to make a complaint, but they said that they had not had cause to do so. We noted that information was available to patients to help them to understand the complaints procedure.

The practice had a system in place for managing complaints and concerns. The practice manager was the nominated person for handling all complaints. Staff told us where possible; concerns were dealt with on an informal basis and promptly resolved.

The practice's complaints procedure was generally in line with current guidance and the NHS Complaints requirements. However, we noted the complaints procedure and information available to patients, did not clearly state that patients could direct their complaint to NHS England rather than the practice. It also did not clearly state that patients could contact the Parliamentary Health Service Ombudsman to investigate second stage complaints. The practice manager agreed to update the information.

The complaints log showed that the practice had received 12 complaints in the last 12 months. This recorded what each complaint related to, which helped the practice manager to consider any trends and patterns. Four complaints we looked at showed that the practice had taken appropriate action to address the issues, and that learning had taken place. The complaints had been acknowledged, investigated and responded to in a timely and transparent way in line with the practice's policy.

Records showed that an annual meeting was held to review all complaints, to ensure that appropriate learning and improvements had taken place, to improve the care for patients.

Staff told us that the practice was open and transparent when things went wrong, and that patients received an apology when mistakes occurred. They also said that lessons learned from complaints were shared with the team, and acted on to improve the services. Records we looked at supported this.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

All patients we received feedback from praised the services they received. Various patients described the staff team and the service as excellent, exceptional and 1st class.

The practice had a clear vision to deliver high quality care and services and to improve the health and well-being of patients. Staff we spoke with understood the vision and aims of the service, and what their responsibilities were in relation to these.

The provider had a generic business plan in place, which set out the short term plans for its three services, which demonstrated a commitment to driving continuous improvements. Senior managers told us that a short term business plan was in place, as the contract to provide primary medical services was currently under review. A longer term business plan would be put in place on securing the new contract.

Governance arrangements

We found that robust systems were in place for gathering, recording and reviewing information about the quality and safety of services that people received, and for identifying, recording and managing risks. Comprehensive risk assessments had been completed; where risks were identified action plans had been implemented to minimise the risks.

There were also robust systems in place to ensure the effective governance of the practice. Senior managers held regular meetings to discuss the business, finances, and performance.

We saw that comprehensive policies and procedures were in place to support the effective running of the practice, which were regularly reviewed to ensure they were up-to-date. Staff had access to the policies; a system was in place to show that staff had been made aware of these. Nine key policies and procedures we looked at had been reviewed recently and were up to date.

We also found that systems were in place to ensure that staff received essential information and were informed of changes.

Various internal and external meetings took place to aid communication and continually improve how the practice delivered services to patients. For example, weekly clinical meeting were held to discuss clinical issues and to share best practice, which the nurses and GPs attended. There were plans to re-commence regular meetings for the non-clinical staff, following the appointment of several new reception staff.

Leadership, openness and transparency

We were shown a clear leadership structure which set out senior staff's lead roles and responsibilities, to ensure that the service was consistently well managed.

High standards were promoted and owned by all staff. All GPs and nurses had lead roles. For example, one GP was the lead manager for the clinical team, clinical commissioning and safeguarding, whilst a further GP was the lead for clinical education, medical student teaching and minor surgery. All staff we spoke with were clear about their own roles and responsibilities, and felt that the practice was well led.

The findings of this inspection showed that the senior management team had the necessary experience, knowledge and skills to lead the team effectively. There was effective teamwork and a commitment to improving patient experiences. The culture and leadership empowered staff to carry out lead roles and innovative ways of working to meet patients' needs, and to drive continuous improvements.

The practice had a highly motivated and committed staff team to enable them to deliver well-led services. All staff we spoke with said they were proud of the organisation as a place to work. There was a very open, positive and supportive culture. This was evident by the response to incidents, significant events and complaints.

Staff told us they felt able to raise any issues with senior managers as they were approachable. The practice manager had an 'open door' policy to discuss any concerns or suggestions. A whistleblowing policy was in place and staff were aware of this, but they had not had cause to use it.

There were high levels of staff satisfaction and engagement. Records showed that regular one to one and team meetings were held, which enabled staff to share information and to raise any issues. All staff said that they enjoyed their work and felt valued and well supported.

Are services well-led?

Outstanding ☆

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

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients, public and staff. Feedback was obtained in a variety of ways, including complaints, surveys and the family and friends test.

Patients and members of the public were encouraged to complete comments forms in the surgery or on the practice's website. For example, one patient had raised the need for a drinks machine in the waiting area. Their suggestion was acknowledged and actioned.

We saw that positive and negative feedback was also obtained by telephone and emails. All comments and complaints were discussed and reviewed at the weekly clinical meetings, and senior managers, where appropriate.

We also saw evidence that the practice had reviewed its' results from the 2015 national GP survey to see if there were any areas that needed addressing.

The practice had an established virtual patient representation group, which enabled a broad range of patients to be involved in developing the service, and have a say about the quality of care they received. Contact with patients was via email.

The practice had recently formed a face to face PPG, which included a group of patients who worked together with the practice staff to represent the interests and views of patients, so as to improve the service. We spoke with two representatives from the PPG. They told us they felt supported in their role, to represent the views of patients to improve the service.

The practice encouraged feedback from staff through away days, meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for patients and staff. Exit interviews were completed for staff that leave the practice. These are reviewed as an organisation, to assess if they could improve on training and development, or any other areas.

Management lead through learning and improvement

The commitment to learning and the development of staffs' skills was recognised as essential to ensuring high quality care. Staff told us that they were actively supported to acquire new skills and further develop their knowledge to improve the services. For example, one nurse had been supported to complete the practice nurse course to develop her knowledge and skills. All nurses had completed training on minor illness and triage to enable them to undertake this role effectively.

The practice had a highly motivated staff team with extensive experience and skills, to enable them to deliver well-led services.

Discussions with staff and records showed that staff received continuous learning, training and an annual appraisal to develop their roles and improve outcomes for patients. All GPs were salaried. In addition to the national appraisal system GP's also had an internal annual appraisal to support their personal development.

Records showed that appropriate learning and improvements had taken place and shared with staff, in regards to incidents, significant events and complaints to minimise further occurrences and improve the service.