St Georges Medical 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?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St George's Medical Practice on 10 February 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing responsive and well-led services and was good for providing safe, effective and caring services.

It was rated as outstanding for providing services to people with long-term conditions and working age people (including those recently retired and students). It was good for providing services to older people, families, children and young people, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice hosted a weekly community clinic which provided a triage service for hip and knee conditions.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients told us they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed.

Summary of findings

- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice including:

The practice was actively involved in developing and implementing innovative pilot projects with other stakeholders to improve patient outcomes across the wider community. For example:

- the practice had hosted and co-authored a liver screening project along with other health professionals from the Nottingham University hospital and the Rushcliffe clinical commissioning group. This project had improved the diagnostic identification of significant liver disease in patients using a fibroscan and had won an NHS innovations award. This was published in the British Medical Journal after our inspection.
- the practice had hosted a trauma and orthopaedic community clinic since April 2014 as a new model of care. This weekly clinic provided a triage service for a range of hip and knee conditions and was led by a consultant and specialist physiotherapist. An evaluation of the service showed positive outcomes were achieved for patients including timely diagnosis and referrals for further intervention, and efficient use of resources including financial savings in terms of inpatient costs. About 87% of patients who had used the service rated it excellent and 13% rated it good.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Robust systems were in place for the regular review of all medicines including for those patients living in care homes. Patients were encouraged to bring their medical equipment for portable appliances test at least once a year to ensure it was safe for use.

Patients were protected from the risk of harm through robust systems in place for safeguarding vulnerable adults and children as well as the recruitment of suitable staff. Appropriate arrangement were in place for dealing with emergencies and management of unforeseen circumstances.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We saw evidence to confirm that these guidelines were improving practice and outcomes for patients. The staff team were committed to working collaboratively with other providers to ensure that patients' received coordinated care and services.

Quality Outcomes Framework (QOF) data for 2013/14 showed the practice was performing above local and national averages in respect of clinical results for long term conditions (6.1 percentage points above the CCG average and 7.7 percentage points above the national average) and in respect of public health indicators (5.4 percentage points above the CCG average and 3.5 percentage points above the national average).

They achieved 100% in all clinical indicators and had sustained this high performance since 2004. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

Summary of findings

The practice had an on-going clinical audit programme, which demonstrated continual improvement to patients care and treatment. The practice used proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Patient's needs were assessed and care was planned and delivered in line with current legislation. Their knowledge of the Mental Capacity Act and deprivation of liberty safeguards was implemented in their practice.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring service

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. This was aligned with the most recent national patient survey results. The results showed most patients rated the practice very good for GP and nurse consultations including care planning and decision making arrangements. 92% described their overall experience of this surgery as good which was above the CCG average of 90% and the national average of 85%.

We saw that staff treated patients with kindness and respect, and maintained their confidentiality. Information to help patients understand the services available was easy to understand. Suitable arrangements were in place to support patients and carers to cope emotionally with their care and treatment.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

The practice had initiated positive service improvements for its patients and wider community that were over and above its contractual obligations. This included hosting an orthopaedic triage service for hip and knee patients, and piloting an innovative diagnostic pathway to detect significant liver disease in the community in collaboration with other stakeholders.

The practice reviewed the needs of its local population and engaged with the NHS England rea Team and Clinical Commissioning Group (CCG) to secure service improvements within the practice and wider

Summary of findings

locality where these had been identified. Staff told us they were all committed to deliver the best care to patients, by staying abreast of all latest professional guidance and by embracing new initiatives of delivering care.

The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments were available on the same day. National data showed high satisfaction scores in respect of access to the service and appointments. These scores were above CCG and national average for all areas.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

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. The strategy to deliver this vision had been produced with external stakeholders and was regularly reviewed and discussed with staff. The practice carried out proactive succession planning including collaborative working with other local practices to create a federated network organisation offering local services of high quality to patients.

High standards were promoted and owned by all practice staff. This included promoting learning and innovation, as well as an open and fair culture for staff. The practice had participated in the productive general practice programme in 2014 and had maintained the positive outcomes achieved. This programme was developed by the NHS institute for innovation and improvement and is designed to help general practices continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Governance and performance management

Summary of findings

arrangements had been proactively reviewed and took account of current models of best practice. Robust systems were in place to identify and manage risks, and to ensure the service was well managed.

The practice had a very active patient participation group (PPG) and proactively sought feedback from staff and patients, which it acted on. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

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.

Every patient over the age of 75 years had a named GP. Influenza and shingles vaccinations were offered in accordance with national guidance.

Nationally reported data showed good outcomes for conditions commonly found in older people (for example osteoporosis and stroke and transient ischaemic attack) and Quality Outcomes Framework (QOF) data showed the practice had achieved and sustained 100% performance since 2006/7 in respect of these conditions. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Outstanding ☆

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

There was a holistic and pro-active approach to meeting patients' needs, with a focus on the effective management and regular review of long-term conditions. Data showed the practice had consistently achieved high rates since 2006/07 that were above the local and national averages for all long term conditions assessed as part of the Quality Outcomes Framework (QOF).

In some cases their performance was significantly better, for example in respect of hypertension the practice performance was 13.4% above the CCG average and 11.6% above the national average. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice reviewed all repeat prescriptions each month (about 300) and 80% of the reviews were face to face consultations with the patient to ensure their medicines remained appropriate for their needs.

Summary of findings

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Benchmarking data in respect of secondary care use showed the practice was in line with the CCG average. Longer appointments and home visits were available when needed.

All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. Effective recall systems were in place to ensure patients attended. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Outstanding ☆

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and those who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

The practice was involved in a range of innovative research projects to improve the outcomes for patients. For example, the practice was involved in a pilot related to nicotine pre-loading which looked at ways to help people to stop smoking and the practice was proactive in developing services that enabled diagnostic tests that reflected the needs of this age group to be carried out at the practice instead of the local hospitals.

Summary of findings

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Data showed uptake rates for health screening were above the local clinical commission group (CCG) averages.

For example, the practice's performance for cervical screening uptake was 86.7%, which was better than the CCG average of 83.4% and the national average of 74.3%. Family planning services were provided by the practice for women of working age.

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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had identified 27 patients with a learning disability. All patients had been offered an annual physical health check and their care plan had been reviewed within the last 12 months.

Much longer appointments (40 minutes) were offered to patients with a learning disability. The practice had access to interpretation services if required.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The staff had told vulnerable patients about how to access various support groups and voluntary organisations and relevant information as available.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

The clinical staff had comprehensive knowledge and understanding of the Mental Capacity Act and were able to give examples of when they had made referrals to the Independent Mental Capacity Advocate service for patients lacking capacity to make decisions and without friends and relatives to support them.

They had also made referrals to the local authority to request an assessment to determine whether a deprivation of liberty should be authorised for two patient's lacking capacity to consent to such a deprivation.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. National data for 2013/14 showed 92.3% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the record, in the preceding 12 months.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Patients experiencing poor mental health were told how to access various support groups and voluntary organisations including MIND and SANE.

The practice carried out advance care planning for patients with dementia and 96 patients had received a dementia diagnosis in 2014/15. Staff had received training on how to care for people with dementia and mental health. The practice offered longer appointments as required and offered home visits for those patients unable to attend the surgery.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 30 completed comment cards. Twenty eight had wholly positive comments, expressing views that the practice offered an excellent service with understanding, caring and compassionate staff, and committed, caring GPs. Two cards contained comments about the patients' individual care and treatment; however the two comments were unrelated.

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

The practice had conducted a patient survey during October and November 2014 of which 235 patients responded. Responses were positive with 112 replies praising the practice in various ways including the clinical care provided. In addition, 123 responses made comments or suggestions for improvements, most of which were positive suggestions. For example, a suggestion was made to use other communication methods such as emails or texts to advise people when flu jab sessions were arranged.

The majority of patients rated the practice as very good and the January 2015 friends and family tests results showed 75% of respondents would recommend the practice.

The practice worked with the patient participation group (PPG) to improve the delivery of care. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

We looked at the results of the national patient survey published in January 2015. Questionnaires were sent to 257 patients and 113 people responded. This was a 44% response rate. Patient feedback was largely positive with: 93% of respondents describing their experience of making an appointment as good, 92% had confidence and trust in the last GP they saw or spoke with and 92% described their overall experience of this surgery as good.

Outstanding practice

- The practice had hosted and co-authored a liver screening project along with other health professionals from the Nottingham University hospital and the Rushcliffe clinical commissioning group. This project had improved the diagnostic identification of significant liver disease in patients using a fibroscan and had won an NHS innovations award. This was published in the British Medical Journal after our inspection.
- The practice had hosted a trauma and orthopaedic community clinic since April 2014 as a new model of care. This weekly clinic provided a triage service for a range of hip and knee conditions and was led by a consultant and specialist physiotherapist. An evaluation of the service showed positive outcomes were achieved for patients including timely diagnosis and referrals for further intervention, and efficient use of resources including financial savings in terms of inpatient costs. About 87% of patients who had used the service rated it excellent and 13% rated it good.

St Georges Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to St Georges Medical Practice

St Georges Medical Practice provides primary medical care services to approximately 9,860 patients. The practice is based in a building in the centre of West Bridge ford which is a suburb of Nottingham. The address where the regulated activities take place is: 93 Musters Road, West Bridgeford, Nottingham, Nottinghamshire NG2 7PG.

Although the practice served a large number of affluent, professional people, within the practice area there were pockets of social deprivation, including a local drop in centre for homeless people or people with drug and alcohol problems.

The practice has a personalised medical services (PMS) contract with NHS England. This is a contract for the practice to deliver enhanced primary care services to the local community or communities over and above the general medical services (GMS) contract. The enhanced services offered included extended hours, minor surgery procedures, alcohol screening and support to older people in care homes

There are six GPs at the practice, three are partners, and three are salaried GPs. There are three male GPs and three female GPs. In addition the nursing team comprises of three nurses and one health care assistant. There are 4.75 whole time equivalent GPs working at the practice.

In addition there are 2.89 whole time equivalent nurses, including health care assistants. The clinical team are supported by the practice manager and an administrative team of ten. Two of the receptionists have a dual role of reception and phlebotomy.

The practice was a teaching practice for first, second and fifth year medical students.

St Georges Medical Practice has opted to take part in the Prime Minister's challenge fund weekend pilot. This has seen the practice working co-operatively with other GPs in the local area to provide a GP service on both Saturday and Sunday mornings and on Bank holidays.

During the evenings and after 1:00 pm at weekends an out-of-hours service is provided by Nottingham Emergency Medical Services (NEMS) through the 111 telephone number.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to

Detailed findings

look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before under our new inspection process and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 February 2015.

During our visit we spoke with a range of staff (GPs, nursing staff and administration and reception staff) and spoke with six patients who used the service. We observed how people were being cared for and talked with patients. We reviewed 30 comment cards where patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported accidents, incidents and used national patient safety alerts as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example needle stick injuries had been reported and responded to in line with the practice policy, and records showed that the correct procedures had been followed.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 24 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints.

We reviewed eleven records from the last year. There was evidence that the practice had learned from events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. We tracked 11 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a patient was given the wrong type of influenza vaccine and had their health needs reviewed. This was discussed at a significant event meeting and an apology was given to the patient.

Following this incident a picture list was introduced to help clinicians to identify the correct vaccine. This example demonstrated that where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager electronically to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

For example, clinical staff were aware of a recent alert which stated women of child bearing age should not be prescribed sodium valproate (a medicine used to treat epilepsy). They told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed that all staff had received relevant role specific training on safeguarding.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

Safeguarding training for both vulnerable adults and children had been delivered across all staff grades at the practice. The training records showed that most staff had received an update or refresher training within the last twelve months.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records and this was audited every six months. This included information to make staff aware of any children subject to child protection plans and patients with a high number of accident and emergency (A&E) attendances.

Good

Are services safe?

The practice maintained a looked after children register which was regularly reviewed with other healthcare professionals. We saw an alert was placed on all family members where safeguarding concerns within a household were reported. This ensured coordinated care and support for both the patient and their relatives.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. 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. All nursing staff, including health care assistants, had been trained to be a chaperone.

Reception staff would act as a chaperone if nursing staff were not available. Receptionists had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. This was verified by the staff training records.

Records reviewed showed the practice identified and followed up on children, young people and families living in disadvantaged circumstances, including looked after children, children of substance abusing parents and young carers. GPs attended child protection case conferences and reviews where appropriate. Reports were sent if GPs were unable to attend. The practice took a multi-disciplinary approach to supporting and protecting vulnerable children registered at the practice and this was confirmed by evidence we saw.

GPs were using codes on their electronic system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the multi-agency safeguarding hub (MASH), police and social services.

Medicines management

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

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

We saw records of practice meetings and a clinical audit that noted the actions taken in response to a review of prescribing data. For example an audit of quinolone (an antibiotic medicine commonly used to treat urinary tract infections) prescribing had been completed.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

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

A senior GP sent notifications to other clinicians when drug alerts were received. Each GP was responsible for identifying the patients needing a review in response to the alert and ensuring any required changes were made.

Cleanliness and infection control

The premises were clean and tidy. There were cleaning schedules and cleaning records were kept. Patients told us they found the practice clean and had no concerns about cleanliness or infection control.

An external company was contracted to clean the practice and cleaning audits had been completed. The practice had carried out an infection control audit for 2014 and highlighted actions were completed on time. For example, open bins had been replaced by pedal bins and the cleaning company were using colour coded cleaning materials. Minutes of practice meetings showed that the findings of the audits had been discussed with practice staff.

An infection control policy and supporting procedures were available for staff to refer to. There was personal protective equipment including disposable gloves, aprons and coverings available for staff to use and staff used these to comply with the practice's infection control policy. There

was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Information about the Ebola virus was available for patients who had travelled, or who were travelling to West Africa.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We observed nursing staff using alcohol gels. Staff training records identified that staff had received training in infection control and hand hygiene.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) and systems to risk assess and monitor this needed strengthening. This included the risk assessment and frequency at which checks were being completed to reduce the risk of infection to staff and patients. This was discussed with the practice manger and we received confirmation this had been strengthened including training for staff following our inspection.

Equipment

Staff we spoke with told us they had the necessary equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. The practice invited patients to bring their medical equipment for portable appliance at least once a year to ensure it remained safe for use. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer

Staffing and recruitment

The practice had a recruitment policy we looked at six staff files and appropriate recruitment checks had been undertaken prior to staff starting to work at the practice.

There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice regularly undertook a patient population needs assessment and practice staff capacity audits to ensure there were adequate staff available to provide effective patient care.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment and staffing. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: the practice had emergency processes in place for identifying acutely ill children and young people, and ensuring they received same day appointments.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. GPs we spoke with told us of the benefits of having the community mental health team located in a building next door to the practice. The practice monitored repeat prescribing for all its patients and this included an awareness and understanding of the needs of people receiving medication for mental ill-health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies and all staff had received 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 were available in secure areas of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (heart attack), anaphylaxis (allergic reaction) and hypoglycaemia (low blood sugar). 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.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk identified with actions to be taken to reduce and manage the risk.

Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained contact details for staff and other relevant companies. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this and the actions that had been put in place to manage this. For example one GP was able to work remotely and offer telephone consultations when they were unable to attend to work due to poor weather conditions.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and guidelines from the National Institute for Health and Care Excellence (NICE) and local commissioners. We were shown a central database where staff could easily access NICE guidelines related to different health conditions via hyperlinks (computer links to other documents).

We saw minutes of practice meetings where new guidelines were discussed; and required actions agreed. For example; patients taking a specific medicine for the primary prevention of cardiovascular disease, were reviewed and where appropriate the dosage of the medicine was changed in line with the new prescribing guidance from NICE.

Staff carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. Evidence we saw assured us care was planned to meet identified needs and patients were reviewed at required intervals to ensure their treatment remained effective. All staff would ask for or provide colleagues with advice and support to ensure the best outcomes for each patient.

The GPs led in specialist clinical areas such as dermatology, minor surgery and contraception (including fitting and removing intra-uterine devices and implants).

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly and multi-disciplinary care plans were in place to co-ordinate care and minimise the risk of patients being admitted to hospital as emergency patients. We saw that after patients were discharged from hospital they were followed up to ensure all their needs were met.

Management, monitoring and improving outcomes for people

The practice showed us eight clinical audits from the last year. Four of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, having attended training, two GPs had identified that the practice data suggested a lower than average diagnosis rate for colorectal cancer.

They undertook audits between 2000 and 2014. The completed audit showed the diagnosis rates at the practice had increased over the four years, and the practice was in now line with national averages which meant a number of patients had earlier access to specialist treatment. Other examples of audits related to two week wait referrals and palliative care coding.

The practice team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). 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 the implementation of preventative measures.

For example, we saw an audit of quinolone prescribing (a family of antibacterial medicines used to treat a wide range of bacterial infections). The audit highlighted the need to ensure that the patient's travel destination was recorded in their notes and an assessment made and recorded identifying whether it was in an area of high quinolone resistance which may indicate different medicines would be needed to treat infection.

We saw that GPs had a robust system for repeat prescribing and reviewed all prescriptions each month which numbered about 300 including patients on multiple medicines. Eighty percent (80%) of the reviews were conducted during face to face consultations with the patient to ensure the prescription remained appropriate.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The data showed the practice the practice has always achieved maximum clinical points since QOF was introduced in 2004. The 2014/15 QOF data showed the practice had achieved the maximum points for the care of long term conditions such as cancer, heart failure, asthma and diabetes.

The practice worked towards the gold standards framework for end of life care. The practice had a named GP lead for

Good

Are services effective?

(for example, treatment is effective)

palliative care and a palliative care register was maintained. Multidisciplinary meetings were held to discuss the care and support needs of patients and their families.

Key information about the patients' needs and care was recorded on a "special patient notes template" which could be accessed by the out of hour's service. Intermittent audits were undertaken to identify whether patients had died in their preferred place and care had been delivered according to their wishes.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The data for the period covering September 2013 to February 2015 showed the practice was mostly in line with the CCG average when benchmarked against local peer practices in the following areas:

- emergency admissions
- elective admissions (including day case)
- accident and emergency (A&E) attendances and
- outpatient first attendances – all sources of referral

Evidence demonstrated their positive performance were largely due to:

- an effective peer review system where two GPs would discuss the appropriateness of a referral to secondary care before it was made.
- robust systems for case management and inviting people with long term conditions and people experiencing poor mental health to attend their health checks and structured annual reviews. For example, QOF data showed:
- 87% of patients with mental health had a comprehensive care plan in place compared to a CCG value of 76.5% and national value of 74.5%.
- 77.8% of patients with chronic obstructive pulmonary disease were reviewed in the last 12 months compared to a CCG value of 74.7% and national value of 70.2%.
- 91.1% of patients of patients with a cancer diagnosis had a review within three months of diagnosis compared to a CCG average of 82% and national average of 78.2%.
- improved access and involvement in various projects to improve the outcomes for patients and to enable more people to be treated locally by GPs.
- For example, the practice was signed up to the GP spec [a local enhanced service commissioned by the CCG to offer common high quality services to all Rushcliffe residents, irrespective of registered practice. This service considered the following areas: long term conditions, referrals and clinical workforce development for example.
- regular reviews of elective and urgent referrals. The senior partner was the clinical lead for elective care in the CCG and they used their wider role to learn and drive service improvement within the practice ensuring patients received appropriate planned care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Records showed all staff were up to date with attending courses such as annual basic life support. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on the administration of vaccines and cervical cytology.

We noted a good skill mix among the doctors with four having additional diplomas from the Royal College of Obstetricians and Gynaecologists. Two GPs had additional diplomas in family planning. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation.

Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

All staff had received annual appraisals and their learning needs were documented. There were robust systems in place to enable nurses to have a 360 degree feedback as part of their appraisal. For example, one nurse file we looked at detailed the nurse's strengths and weaknesses in relation to clinical skills and knowledge, communication and team working. Staff told us the feedback was useful in supporting their professional development.

Working with colleagues and other services

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. There were systems in

Good

Are services effective?

(for example, treatment is effective)

place to make sure communications with other care providers were acted on (where necessary) on the day they were received. The GP who saw these documents and results was responsible for any action required.

The practice was commissioned for several enhanced services and this included: avoiding unplanned admission, minor surgical procedures, alcohol screening and support to older people in care homes. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice had a process in place to follow up patients discharged from hospital and a dedicated phone number was provided for the ambulance service and hospital to enable them to have quick access to the GPs in emergencies to make decisions which were in the best interests of each patient.

The practice held multidisciplinary team meetings at least monthly to discuss the needs of patients with complex needs, for example those approaching the end of their life care. These meetings were attended by district nurses, the community matron, respiratory and heart failure nurses. This enabled care planning to be reviewed and care to be discussed and coordinated effectively. Care plans were in place for patients with complex needs and were shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there were systems in place for the practice to share essential information about patients with the local GP out-of-hours provider in a secure and timely manner.

Electronic systems were in place for making referrals, through the choose and book system. Choose and book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patients attending the emergency department were given a printed copy of a summary record to take with them to A&E. Summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. Information for patients about summary care records was available on the practice website.

The practice had systems to provide staff with the information they needed. 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

All staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff understood the key parts of the legislation and were able to describe how they implemented it in their practice.

For example, GPs had made referrals to the independent mental capacity advocate (IMCA) service for two patients where concerns over their capacity to make decisions in respect of resuscitation in a medical emergency were noted. This ensured patients were supported by an advocate to have their views heard, their rights upheld and enabled them to make an informed decision. IMCA is a statutory advocacy introduced by the Mental Capacity Act 2005 (the Act) which gives some people who lack capacity a right to receive support from an IMCA.

The practice had also made deprivation of liberty safeguards applications to the local authority for an assessment of whether an authorisation was appropriate for two vulnerable patients who lacked capacity to consent to deprivation and do not resuscitate decisions. This assured us that staff had a very good understanding of these pieces of law which exist to protect patients who lack capacity to consent to specific decisions.

Feedback received from one care home manager showed that a proactive approach was taken by the practice to empower patients in the care home and their relatives to understand the process for arriving at do not resuscitate decisions in a medical emergency. For example, a GP held an open surgery for residents and / their families in April 2014 to support them understand the process and facilitate where required.

There were consent policies in place which highlighted how patients should be supported to make their own decisions and how these should be documented in the

Good

Are services effective?

(for example, treatment is effective)

medical notes. A GP gave us an example of a patient who had dementia, and lacked capacity to make a specific decision and they told us how they had been involved in making a best interest decision for this patient.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We found care plans for all 27 patients on the practice's learning disability register had been reviewed within the last year.

All clinical staff demonstrated a clear understanding of Gillick competencies, which are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

There was a practice policy for documenting consent for specific interventions. For example, all minor surgical procedures including fitting and removing intra-uterine devices and implants) required a patient's verbal and written consent to be documented with a record of the relevant risks, benefits and complications of the procedure.

An audit confirmed the consent process for minor surgery had being followed in 100% of cases and the results were discussed in the clinical update meetings. All clinical staff were reminded to gain written consent for invasive procedures.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

As a number of GPs had extra training and an interest in sexual health there was a commitment to offering opportunistic chlamydia screening to patients aged 18 to 25 years to promote and maximise their health and wellbeing. GPs also offered smoking cessation advice to smokers.

The practice offered NHS health checks to all its patients aged 40 to 75 years. Practice data showed that 60% of patients in this age group took up the offer of the health check since January 2015 which was above CCG average. Patients were followed up within weeks if they had risk factors for disease identified at the health check and further investigations were scheduled promptly if needed.

The practice's performance for cervical screening uptake was 86.7%, which was better than the CCG average of 83.4% and the national average of 74.3%. Telephone reminders were used for patients who did not attend for cervical smears and the practice audited patients who did not attend. There was a named nurse responsible for following up patients who did not attend screening.

Performance for national chlamydia, mammography and bowel cancer screening in the area were all above average for the CCG**,** and a similar mechanism of following up patients who did not attend was used for these screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations compared favourably against rates of immunisation within the CCG. For example:

- 95.5% of all children up to 12 months of age had received the diphtheria, pertussis (whooping cough), polio and tetanus (DPPT) vaccine and
- 97.1% aged up to 24 months had received the measles, mumps and rubella (MMR) vaccine.

We saw that the practice worked closely and collaboratively with midwives, nurses and health visitors.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015, a survey of 235 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice partners. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the majority of patients rated the practice as good or very good. The practice had satisfaction scores broadly in line with the CCG and national averages for consultations with doctors and nurses. For example:

- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 93% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 90% and national average of 97%.
- 92% describe their overall experience of this surgery as good compared to the CCG average of 90% and national average of 85%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards and 28 were wholly positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We received specific comments relating to the population groups we inspected. For example, comments highlighted that good care was provided for children with complex needs; continuity of care had been maintained for patients experiencing poor mental health and early diagnosis of cancer had been facilitated for a patient.

We spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Records reviewed showed staff had received training in customer service and dignity and respect to inform their practice. The national patient survey results showed 94% of the practice respondents found the receptionists helpful. The practice maintained records of complimentary comments and we saw many thank you cards received from patients in respect of the good care provided.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Material curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained. We saw that the curtains were deep cleansed every six months. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. A system had been introduced to allow only one patient at a time to approach the reception desk in response to patient and staff suggestions. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

The national patient survey information from January 2015 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:

- 94% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 96%.
- 88% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 82%.

Comparable values were achieved for nurses, for example:

Good

Are services caring?

- 92% 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%.
- 88% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national averages of 85%.

The results from the practice's own satisfaction survey showed most patients said they were sufficiently involved in making decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language to ensure they were fully supported in decision making about their care. We saw notices in the reception areas informing patents this service was available. Staff told us this service was not often used as 98% of the practice population spoke English as their first language.

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

The practice worked with the community matron and district nurse to ensure care plans for older people and people with long-term conditions were in place. We saw that these patients had up to date care plans, which were shared with other colleagues and professionals involved in their care. This included information about end of life planning where appropriate.

We were shown records to evidence collaborative working between the practice, patient and their family, palliative and district nursing teams to ensure a patients wish to die comfortably within their home had been respected.

For patients experiencing poor mental health including those patients with dementia we saw evidence of advanced care planning for patients with dementia, this involved early diagnosis and helping people to make decisions while they were able to do so.

Staff had access to a range of advance directive resources and a system was in place to highlight if a patient had an advance directive / decision in their electronic record. An advance decision is a statement explaining what medical treatment an individual would not want in the future, should they lack capacity.

Specific patient wishes including do not attempt cardio pulmonary resuscitation were highlighted so that the clinician could easily access this information when they opened a patient record. These wishes were reviewed bi-annually to ensure they remained current.

The practice had completed comprehensive care plans for 2.2% of the practice population at risk of unplanned admission. This was slightly above the recommended 2%. GPs we spoke with told us developing the care plans with the patients ensured they understood the care and treatment choices available to them, and clinicians took account of their views in the way care was provided. Robust systems were in place to ensure the care plans were regularly reviewed and remained reflective of a patient's current needs.

We saw evidence to demonstrate that children and young people were treated in an age-appropriate way and recognised as individuals with their preferences considered.

Patient/carer support to cope emotionally with care and treatment

The national survey information from January 2015 showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example,

- 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 85%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Good

Are services caring?

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. This included information on MIND, a national charity which helps and advocates for people experiencing poor mental health.

The practice's computer system alerted GPs if a patient was a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them and a carer's notice board was available in the waiting area.

Staff told us that if families had experienced bereavement, their usual GP contacted them. One patient we spoke with who had experienced a family bereavement confirmed they had received this type of support and said they had found it helpful. There were pathways in place to refer patients to bereavement counselling if required.

The practice staff were aware that isolation was a risk factor for older patients. To address this, older patients were given more time during consultations and the practice used a multi-disciplinary team approach to offer support and address issues of potential isolation. After the practice's multi-disciplinary meeting a range of clinicians were set task reminders to contact patients and check on their wellbeing.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered a wide range of services to meet its patients' needs. This included: ante-natal and maternity care; child health promotion; family planning; well person checks; immunisations and travel vaccinations. Patients with long term conditions could arrange to see a nurse by appointment without having to attend set times for clinics; other than when the specialist diabetes nurse attended the practice.

A GP told us this allowed clinical staff to have a range of skills, rather than focussing on a small clinical area and range of needs. This also ensured flexibility and patient choice in arranging a convenient time around their needs and was especially helpful for working patients who constituted the majority of the patient population.

The practice undertook weekly visits to two nursing homes and this included a review of any unplanned admissions over the previous week and consideration of any avoidable factors. Feedback received from two care home staff was very positive. They told us patients' health conditions and medicines were reviewed regularly and the practice accommodated patients' needs.

The practice engaged regularly with the NHS England Area Team, Rushcliffe CCG, Nottingham University Hospital and other practices to discuss local needs and service improvements that needed to be prioritised.

This included: developing and implementing community based care pathways; better utilisation of resources to improve patient care and the recruitment of additional practice nurses to support the GPs. We saw records where this had been discussed and actions agreed to address the identified needs and manage delivery challenges to its population. Robust systems were in place to review, maintain and / or adjust the level of service provided.

We found several examples to demonstrate that the practice was very responsive to its patient's needs and those of the wider community. Specifically, the practice recognised that it was essential to work collaboratively with other organisations in the planning and delivery of health services that were tailored to meet the needs of each individual patient. For example, the practice had hosted a trauma and orthopaedic community clinic since April 2014 as a new model of care.

The weekly clinic provided a triage service for a range of hip and knee conditions and was led by a consultant and specialist physiotherapist. An evaluation of the service which was completed showed the following positive outcomes:

- 630 referrals were triaged by a consultant over a one year period and 90% of patients had chosen a community appointment at the GP practice.
- Two thirds of patients went on to be offered further intervention such as surgery and a third of patients were discharged, reducing a number of unwarranted interventions.
- Secondary care colleagues felt the clinic allowed more focused patient care, in a better environment with more timely and responsive services.
- Efficient use of resources including financial savings in terms of inpatient costs
- About 87% of patients who had used the service rated it excellent and 13% rated it good.
- There was no increase in Rushcliffe's clinical commissioning group (CCG) standardised admissions ratios data for joint replacement compared to increases in neighbouring CCGs.

The practice participated in developing and implementing innovative approaches that aimed to provide integrated person centred pathways of care for its patients and the wider community. For example, the practice had identified that alcohol consumption in the relatively affluent suburban population was rising and 'normalised' by patients.

Research findings showed that deaths from liver disease had continued to increase in the UK. Therefore, the identification, prevention and treatment of liver disease is recommended as a priority area.

In response to this health need, the practice worked in liaison with other health professionals from Nottingham University Hospital, CCG and another local practice in a pilot project to screen patients who had risk factors for cirrhosis (scarring of the liver due to long-term liver damage). This included patients with above average alcohol consumption or diabetes. About a third of the 100 screened patients had significant liver damage and 70% of these had normal blood tests.

The use of a fibroscan as a diagnostic tool during this pilot identified twice as many patients with cirrhosis than the

Are services responsive to people's needs?

(for example, to feedback?)

practice was aware of. This confirmed its use was more effective in determining patient's liver health compared to blood tests usually taken. The results of this pilot enabled further study to occur in inner city practices and fibro scanning has now been rolled out as a routine investigation in the detection of early liver changes.

The findings of the entire pilot project (including results from another local practice) showed improved outcomes for patients as a result of early cirrhosis detection and potential cost saving for the NHS (over the long term). For example:

- Providing 95% of the diagnostic investigations in the community enabled patients to have instant feedback of their results rather than waiting for investigations at the hospital which can take between four weeks and six months.
- Cost benefits to patients, with reduced visits and time taken off work to travel to hospital appointments and
- The reduction in the number of inappropriate referrals made to secondary care, out-patient visits to the hospital and prevention of repeated hospital admissions as the delivery of the care pathway is community based.

The practice had implemented several suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

For example, the practice have provided more telephone cover at peak call times and more training for reception staff to improve patient access and experience. Additionally, the practice improved the way of sharing test results with patients, and has placed a tab titled "care data" on the practice website to help increase awareness of the care data record initiative and a choice to opt out of patient information being shared.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times and home visits were available for patients with learning disabilities (40 minutes), older people and people experiencing poor mental health. A room was available for infant feeding and breastfeeding.

The practice kept a register of patients who may be living in vulnerable circumstances and a system for flagging vulnerability in individual records was in place. Patients who were homeless were easily able to register with the practice using the practice's address. The practice aimed to provide a non-discriminatory service and respect patient's beliefs and lives.

The practice had a population of 98% English speaking patients and access to translation services was available for patients who needed them. There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. Staff we spoke with confirmed they had completed equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patient with disabilities. For example, the practice building was purpose built in 2004 and was situated on the first, second and third floors of the building. All services for patients were on the first floor and there was lift access to all the floors. There was an automatic door at the front entrance and on-site disabled parking spaces behind the building.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. The reception area had a lowered height counter and adjustable beds were available in some of the consultation rooms to allow for improved access for disabled patients. Accessible toilet facilities were available for all patients including baby changing facilities.

The practice actively supported patients who had been on long-term sick leave to return to work by promoting the 'fit note' on its web site and signposting them to the job centre for help. The fit note was introduced in April 2010, and enables patients to give more information to their employer about their illness or injury and therefore get back to work quicker.

Access to the service

The national patient survey results published in January 2015 showed high levels of patient satisfaction with access to the service and appointments. Patients responded positively and rated the practice well in these areas; and satisfaction rates were above the local and national averages. For example:

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 97% said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.
- 93% described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.
- 88% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65% and
- 84% were satisfied with the practice's opening hours compared to the CCG and national averages of 75%.

Patients we spoke with were satisfied with the appointment system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to book routine and urgent appointments in person and on-line. We found the practice opened from 8am until 6.30pm daily; and extended hours were offered on most Tuesdays between 6:30pm and 8pm. This was particularly useful to patients with work commitments and patients who found it difficult to attend the surgery during normal surgery hours. This was confirmed by two patients we spoke with; they said they often came in the evening as it was more convenient.

Appointments were available from 8.30 am to 12pm and 4pm to 6pm on weekdays; and an earlier afternoon surgery was available on some Tuesdays and Wednesdays. This included appointments with a named GP or nurse. There were appointments available outside of school hours for families, children and young people.

Longer appointment times were available for patients who needed them including those with long-term conditions and children attending new baby and eight week checks. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients could access GP appointments on Saturday and Sunday by telephoning 111. This service was being provided as part of the Prime Minister's challenge fund weekend pilot for all Rushcliffe patients and the practice's GPs participated in this by working weekends. This service was based at another practice.

Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

To ensure improved access for patients, the practice regularly monitored the demand and provision of appointments and telephone consultations, and made changes where needed. Improvements had been made as a result of: an independent review of four weeks of data recording patient requests for GP appointments in November and December 2014; and practice staff participating in the productive general practice (PGP) programme in January 2014. This programme was developed by the NHS institute for innovation and improvement and is designed to help general practices continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations.

The practice data showed there were insufficient appointments to cope with demand at times, especially when there was annual leave or sickness and on a Monday. In response to this, the practice increased on the day appointments on Mondays as well as increased nursing staffing times including appointments with the phlebotomist and health care assistant.

These changes provided patients with a greater availability and choice of appointments. Additionally, this relieved some of the pressures for staff on Monday, by having an increased availability of on the day slots and allowed for a more appropriate spread of the workload in relation to their skill mix.

Listening and learning from concerns and complaints

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system. There were posters and leaflets in the waiting area explaining the process available. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last 12 months. We found that one had been referred to the Ombudsman by the patient, two complaints were pending and the fourth had been handled as a significant event. Records showed that the practice had dealt with the complaints in a timely way and with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

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

The practice had a clear vision to consistently provide excellent quality of care and promote good outcomes for patients. The vision included providing safe and compassionate care in partnership with patients and to continuously improve the services offered.

The fulfilment of this vision was confirmed by patient feedback and records we reviewed. For example, positives outcomes were achieved for patients as a result of the practice's participation in pilot projects and improvement work in liaison with other stakeholders.

One significant example was the practice had hosted and co-authored a liver screening project along with other health professionals from the Nottingham University hospital and the Rushcliffe clinical commissioning group (CCG). The project achieved to improve the diagnostic identification of significant liver disease in patients.

The Department of Health had provided a capital investment of £30 000 to purchase the portable fibroscan used in the diagnostic tests. This pilot project won an NHS innovations award and the results of the work and clinical outcomes was published in the British Medical Journal after our inspection.

The practice values stated the way in which the practice should work. For example, being open, honest and transparent; investing in staff training and encouraging community engagement. The vision and values were displayed in the reception, staff room and training rooms. They had been developed with input from staff, patients and the CCG.

We spoke with nine members of staff and they all knew and understood the vision and values, and knew what their responsibilities were in relation to these. Records we looked at showed staff had discussed and agreed that the vision and values were still current.

We found a systematic approach was taken to working with other local practices within the CCG to improve patient outcomes, tackle health inequalities and obtain best value for money across the wider patient community. For example, delivery of some secondary care services within the practice which were accessible to patients within the local community and not just practice patients.

In addition, the senior partner told us all 12 practices within the Rushcliffe CCG were in the process of translating the implications of the NHS five year forward view locally. This included proposals of a federated network organisation so as to offer more local services to the patients. The leadership felt this would ultimately be the succession strategy.

The NHS five year forward document was published in October 2014 and sets out actions that need to be taken in respect of some of the following areas: preventative action to prevent ill-health; empowering patients to take more control of their own care; support for carers; the delivery of integrated and person centred care through flexible and new models of care.

The practice was very much aware of the challenges it faced, this included the recruitment of practice nurses and a shortfall of doctors choosing a career in general practice. In response to these concerns, the practice along with other Rushcliffe practices, were considering putting forward a proposal to become a community education provider network (CEPN). A CEPN aims to capture innovation and education across primary and secondary care, and engages patients and the public.

Governance arrangements

The practice had a strong clinical and managerial leadership structure in place. This included three GP partners, a senior nurse who managed the nursing team and an experienced practice manager who managed the administration and reception staff. Named members of staff had lead roles in areas such as: routine chronic disease management, research and training. All nine staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP partners and the practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included reviewing the data from the primary care quality web tool, performance packs from the CCG and the Quality and Outcomes Framework (QOF) to measure the practice's performance. QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

Are services well-led?

Outstanding ☆

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

The 2013/14 QOF data for this practice showed it was performing above national average for all the 20 clinical areas assessed. It had achieved a total of 99.7% which was 5.1 percentage points above CCG average and 6.2 percentage points above England average. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice held monthly governance meetings. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a full cycle audit was undertaken to ensure that processes for implant fits and removals were in line with best practice and that complication rates were at acceptable levels. The results of the 2014 audit showed no patients sustained any complications.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We reviewed a number of policies, for example recruitment, health and safety and medicines management which were in place to support staff. Most staff had completed a cover sheet to confirm that they had read the policy and when. All policies and procedures we looked at had been reviewed regularly and were up to date.

Leadership, openness and transparency

The leadership told us they promoted a flat structure where every staff member was valued and listened to. This was corroborated by staff we spoke with. For example, staff told us that an open and supportive culture was promoted within the practice and they all had the opportunity and were happy to raise issues at team meetings. We saw from minutes that team meetings were held regularly. For example, the practice held a monthly practice meeting and clinical update meeting during which suggestions for improvement were made.

Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The leadership told us that participating in the productive general practice (PGP) programme promoted an open culture where staff and two patient participation group (PPG) members evaluated existing services and agreed improvement areas. The PGP programme was developed by the NHS institute for innovation and improvement and is designed to help general practices continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations.

As a result of this programme, the team were able to improve work processes, develop better services for the patients and improve the overall productivity of the practice. Examples of changes made included improved access and increase to the nursing team. We found the practice had a committed staff team to enable them to deliver well-led services.

We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the PPG, annual surveys, comments and suggestions box in the waiting area and complaints received. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The practice had an active PPG which met every two months. The practice manager showed us the analysis of the most recent patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The results showed most respondents were complimentary of the appointment system, the care delivered by the GPs, nurses and reception staff, and an overall good experience. Areas of improvement that had been identified included improving waiting times and phone access; both of which were regularly reviewed by the practice.

Are services well-led?

Outstanding ☆

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

The chair and vice-chair of the practice's PPG are part of the Rushcliffe CCG's patient active group which regularly meets to discuss issues affecting Rushcliffe patients, providing a valuable link for communicating between the two groups.

The practice had gathered feedback from staff through a staff survey and generally through staff meetings, appraisals and discussions. The staff survey undertaken in January 2014 as part of the productive general practice programme showed practice staff were satisfied with the following areas: decision making; team working; internal communication, change and innovation.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The leadership encouraged staff participation in social events and paid Christmas bonuses in recognition of staff's hard work.

Management lead through learning and improvement

The practice had a strong focus on continuous learning and improvement at all levels of the organisation. For example, the senior partner had achieved the certificate in leadership for quality improvement and they told us this was helpful in undertaking their lead role in quality improvement; as well as encouraging staff to be open to new ideas and aware of change. The practice manager was the chair of the Rushcliffe practice managers' forum, which meets monthly, to provide support, training and share best practice.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan.

The practice was an established training practice, having been training for over nine years. Two of the GP partners were trainers and one of them was a programme director for the Nottingham GP Training scheme. At the time of our inspection there were three registrars working in practice. Records we looked at showed registrars felt well supported in their learning and had a suitable induction. The practice was a teaching practice for first, second and fifth year medical students.

Records reviewed showed the practice had engaged in research trials to improve services for patients. The practice had an agreement in place to undertake at least two research studies per year with the clinical research network primary care team. One recent trial included nicotine pre-loading which looked at ways to help people to quit smoking.

Nicotine preloading is the use of nicotine replacement therapy / patches before a patient stops smoking. Practice data showed 21.93% of the practice's patient were smokers and 77.4% of these patients had been offered support to stop through the practice. Many patients had taken advantage of the nicotine preloading trial as part of the research.

The senior GP told us it was important to offer the patients the opportunity to be involved in research as part of working together towards improving health and social care for all. Records reviewed and discussions with staff confirmed a proactive approach was taken to seeking out and embedding new ways of providing improved care to patients.

The practice had achieved "Research Ready" accreditation by the Royal College of General Practitioners (RCGP). Accredited practices receive certification that acts as a quality mark to demonstrate that they have the ability to safely carry out research.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings and away days to ensure improved outcomes for patients. For example, following the vaccine fridge temperature increasing above the recommended temperatures, the practice ensured the safe disposal of vaccines.