

# The Ivy Medical Group

## 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		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Requires improvement	

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Ivy Medical Group on 11 April 2017. Overall the practice is rated as good.

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

- There was an effective system in place for the reporting, recording and analysis of significant events. This included near misses and incidents relating to the dispensary service. Lessons were shared to improve safety in the practice, and an annual review had been established to review outcomes and to observe any trends or themes.
- The practice had developed an effective procedure to respond to national safety alerts including those received from the Medicines Health and Regulatory Authority (MHRA). A comprehensive log detailed all alerts that were received, and provided evidence of the follow up action that was taken to keep patients safe.
- The provider had clear arrangements in place to ensure the proper and safe management of medicines.

Processes and governance arrangements for managing medicines had been recently reviewed and were working effectively. This included the prescribing, recording, handling, storing, security and disposal of medicines.

- The dispensary was located in shared premises with another practice's dispensary. The location presented some challenges with regards to security but the practice had identified this and was working to find a long-term solution. Risk assessments were in place to control the area of concern that had been identified.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance, and had documented evidence to support this. Clinical meetings ensured staff kept up to date with new developments.
- The practice was recruiting for additional clinical staff and was due to undertake a national GP recruitment campaign in collaboration with their CCG. Staffing levels at the time of our inspection did not always ensure the needs of patients were met in a consistent or timely way, and the practice was reliant on regular locum GP sessions.

# Summary of findings

- Staff were supported to complete essential and role-specific training and received appraisals.
- The most recent National GP Patient Survey (July 2016) indicated that patient satisfaction was generally below local and national results in terms of consultations with clinicians and access to appointments. The practice had devised an action plan to improve this with their patient participation group (PPG), and undertook their own internal patient survey to review progress. This indicated that patient satisfaction was improving.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had a main site at Burton Joyce and a branch site shared with another GP practice at Lowdham. The practice had mostly good facilities and was equipped to treat patients and meet their needs. The two sites required some refurbishment and the practice worked with their CCG to review any funding opportunities to support redevelopment.
- There was a clear leadership structure and staff felt supported by management.
- The practice had governance systems in place which were effective and supported the delivery of good quality care and ensured effective oversight.

- The practice participated in new models of care and local pilot schemes to improve patient outcomes in the local area. There was strong engagement with the Clinical Commissioning Group (CCG) and with other local GP practices.
- The practice had a clear forward strategy and were actively looking at ways to develop a structure and model that was fit for purpose to meet future demands.

The areas where the provider should make improvement are:

- Continue to review the practice staffing levels to ensure patients' needs are met. This should include both clinicians and non-clinical staff.
- Continue to review, monitor and act upon patient experience data (including the national GP patient survey results) to drive service improvement and improve patient satisfaction.
- Review the practice training matrix and customise this to reflect the practice team's training requirements.
- Ensure staff appraisals are updated and reviewed on a regular basis.
- Continue to explore a longer-term solution to the security and confidentiality arrangements within the practice dispensary

**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



- There was a system in place for reporting, recording and analysing significant events and near misses. Lessons were shared to improve safety in the practice, and an annual review was undertaken to analyse and address any themes or trends.
- The practice had a robust procedure to manage patient safety alerts. A comprehensive log detailing information on all alerts and the actions undertaken in response was maintained.
- The practice operated an effectively managed procedure to ensure patients on high-risk medicines were regularly monitored to keep them safe.
- The provider had safe arrangements in place to ensure the proper and safe management of medicines. This included the processes of recording, prescription handling, safe keeping and dispensing of medicines.
- The dispensary premises were shared with another practice in an open-plan environment and whilst this created issues with security and confidentiality, the practice was actively working to address this.
- The practice had effective procedures in place for dealing with emergencies, and staff received regular life support training appropriate to their roles.
- The practice had suitable arrangements in place to safeguard patients from abuse and this included effective and regular liaison with the health visitor.
- Risks related to infection control, health and safety, the premises and environment had been assessed.
- The practice was trying to recruit additional clinical staff as existing staffing levels did not always ensure the needs of patients were responded to in a timely way. The practice was due to embark with their CCG on a national GP recruitment campaign, and was recruiting more reception staff and an advanced nurse practitioner role.

### Are services effective?

Good



- Published data for 2015-6 from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average national averages. For example, the practice had achieved 97.9% of the total number of points available which was 2.1% above the local average and 2.6% above the national average.

# Summary of findings

- Staff had the skills, knowledge and experience to assess patients' needs and deliver care and treatment in line with current evidence based guidance. This was supported by an effective process for disseminating new and updated guidance to clinicians.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. For example, regular multidisciplinary meetings were held to discuss patients at high risk of hospital admission, those receiving end of life care and people experiencing poor mental health.
- Clinical audits were completed and used to drive improvement in patient outcomes.
- An induction and training programme was in place and there was evidence of appraisals and personal development plans for staff. Staff appraisals were due to be reviewed and these had been scheduled with the recently appointed practice manager.

## Are services caring?

- We observed that staff treated patients respectfully and with kindness during our inspection.
- The most recent national GP survey highlighted satisfaction rates for consultations with GPs and nurses were lower than local and national averages. The practice team and PPG were aware of the lower patient satisfaction scores and had identified an action plan in response to the patient feedback in order to drive improvements in patient experience. The practice had undertaken their own internal patient surveys which demonstrated an improvement in satisfaction levels.
- Feedback from multi-disciplinary colleagues was very positive. They described the practice as being very responsive and told us the practice delivered care via a patient-centred approach. They also told us that communications with the practice were good and that their views were always respected.
- There was designated carer's champion and the practice had identified 2.2% of their patients as carers. A carers pack and information on support groups and services was made available to them.
- As a small practice, the team knew their patients well which facilitated them in providing personalised care for patients. We were provided with examples of individual patient stories which reflected the caring approach of the practice team.

**Good**



# Summary of findings

## Are services responsive to people's needs?

Good



- The practice team reviewed the needs of its local population and engaged with their clinical commissioning group to secure improvements to services where these were identified. For example, the practice were working with the CCG and two other local GP practices on a recruitment campaign as part of the vulnerable practices scheme.
- A dispensing service was offered at the branch surgery for patients who lived more than a mile from their nearest chemist. A delivery service and monitored dosage systems were provided when required.
- The practice hosted a range of services including family planning advice, chronic disease management, child health reviews and immunisations, ambulatory blood pressure monitoring and a phlebotomy service.
- The practice had developed its website to include extensive health promotion information to improve patient education. In addition, an iPhone application had been made available to patients to improve access to services for patients.
- Comment cards were mostly positive about their experience in obtaining a non-urgent GP appointment, although three of the 17 cards received did indicate long waits.
- Feedback from the most recent national GP survey results in July 2016 indicated lower satisfaction in respect of access compared to local and national averages. For example, 58% of respondents described their experience of making an appointment as good compared to the local average of 69% and the national average of 73%. The practice had developed an action plan in response to this and were monitoring progress via their own internal patient surveys.
- The practice proactively sought patient feedback and as a consequence made changes to the way it delivered services. For example, a new telephone system had been implemented in response to patient feedback and complaints.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.

## Are services well-led?

Requires improvement



- The practice had developed a mission statement and defined values to underpin the delivery of care and promote good outcomes for patients.

# Summary of findings

- There was a clear leadership structure and staff mostly felt supported by management.
- Governance arrangements in place supported the delivery of good care, but sometimes lacked effectiveness due to consistent oversight. There was a network of internal meetings and up to date policies and procedures to govern activity which were implemented in practice.
- The practice had a written business plan to align with the NHS five year forward view. The practice were engaged with federative working with other local providers, and were actively reviewing more integrated working with other local practices.
- The single-handed GP had commitments outside of the practice which impacted on the capacity to provide direct patient care, and this led to a reliance on locums. This impacted on access to GP consultations, and the assurance and oversight of locum work. Non-clinical staff capacity was limited by the number of staff working across the two sites.
- The practice participated in new models of care and local pilot schemes to improve patient outcomes in the local area.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and helped to influence practice developments. However, practice surveys were inconsistent in approach which meant that outcomes were difficult to benchmark.

# Summary of findings

## The six population groups and what we found

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

### Older people

Good



- The practice had the fourth highest proportion of older patients across the 20 practices within the CCG. Approximately 11.5% of patients registered at the practice were aged 75 or over and services were tailored to meet their needs.
- The GP could refer patients for a social care needs assessment through their links with a named social worker and a community care officer.
- The health needs and care plans for older people at risk of hospital admission or deteriorating health was discussed at regular multi-disciplinary meetings, to ensure they received appropriate care.
- Home visits and longer appointments for patients with enhanced needs were available. The practice provided a home phlebotomy service to ensure older people received the care they needed to monitor their health needs, and had implemented a delivery service to housebound patients who had their medicines issued via the practice dispensary.
- The practice was a member of the 'Primary Care Home' pilot to improve services for older patients in the community to reduce their need to travel to hospital.
- The practice had recently commenced input to a local care home as part of the 'one care home, one practice' initiative. This helped with continuity and established a more proactive and responsive service for residents.
- The practice worked with Age UK and planned to set up tea mornings to help address social isolation, and to develop a further opportunity to identify their patients' needs.

### People with long term conditions

Good



- Data reviewed showed outcomes for patients were at or above local and national averages.
- Clinical staff worked closely with community nursing teams, care staff and the voluntary sector to manage the care of patients with complex health needs. This included facilitating regular multidisciplinary meetings attended by the community respiratory nurse, district nurses, community matron, Macmillan nurse and Age UK.



# Summary of findings

- Patients at risk of hospital admission were identified as a priority and their care was kept under review to ensure they received integrated care in the community.
- The practice participated in the national diabetes prevention programme for patients in line with the NHS diabetes prevention programme. As part of this programme, patients identified at high risk of diabetes were referred onto an evidence-based behaviour change programme to help reduce their risk. This included education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, which reduced the risk of developing the condition.
- The diabetes nurse specialist attended a joint monthly clinic with the practice nurse to review patients with diabetes to initiate insulin, or to review more complex problems.
- Patients were offered a structured annual review to check their health and medicines needs were being met. The reviews were planned around the patients' date of birth and patients who did not attend scheduled appointments were actively monitored which ensured low levels of exception reporting.

## Families, children and young people

Good



- Appointments were available outside of school hours and all children aged under five were seen on the day if medically assessed as necessary. Children under one year of age were booked as extras on the appointment list without the need for triage.
- There were systems in place to identify and follow up children living in disadvantaged circumstances including those at risk of abuse or deteriorating health.
- Records reviewed showed positive examples of joint working with midwives, health visitors and school nurses. For example, the health visitor provided child developmental checks and took part in safeguarding meetings.
- Uptake rates for all standard childhood immunisations were relatively high and in line with the local averages.
- The practice provided baby changing facilities and a private room for breastfeeding mothers if requested.

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

Good



- The practice was proactive in offering online services and news/ Facebook/twitter feeds. The practice had achieved a 27% sign

# Summary of findings

up from patients to access online services including appointments and repeat prescriptions. This was significantly higher than the national target of 10%, and also exceeded uptake in other local practices.

- The practice website had been upgraded to include health promotion information and an iPhone application was used to improve access to information and services for patients.
- Health promotion for this age group included advice and support with weight management, smoking and alcohol cessation.
- The practice promoted cancer screening programmes and uptake rates were in alignment with local and national averages. For example, 83% of females aged between 25 and 64 years had a record of cervical screening within the target period compared to a local average of 86% and national average of 82%.
- The practice used a text messaging service to remind patients of appointment bookings.
- NHS health checks were being actively promoted and the practice had worked hard to increase uptake in the last six months through the use of computer prompts, and the provision of dedicated clinics.

## People whose circumstances may make them vulnerable

- The practice offered longer appointments for patients with a learning disability
- The practice had eight patients on their learning disability register, and 62.5% of these patients had received an annual health review.
- The practice regularly worked with other health and social care professionals in the case management of vulnerable patients. This included patients receiving end of life care and carers. Patients were also informed about how to access various support groups and voluntary organisations.
- The practice adopted a co-ordinated approach to care planning in collaboration with other professionals, which ensured key information was shared with other providers such as the out of hours service.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. They 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.

Good



# Summary of findings

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

Good



- 2015-16 published QOF data showed that 87.5% of patients with a mental health condition had a documented care plan in the last 12 months which was in line with the local average of 87.8%, and the national average of 88.8%. However, overall exception reporting rates for mental indicators were higher than local and national averages. Practice provided data (subject to external verification) showed that achievement had increased to 100% in 2016-7 and exception reporting rates had reduced.
- 81.8% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was below the local average of 88.5% and the national average of 83.8%. The practice's own data for 2016-7 demonstrated an achievement of 78.1%, but with improved levels of exception reporting.
- The practice regularly worked with multi-disciplinary teams in the case management of patients to ensure they received continuity of care. This included advance care planning for patients with dementia and liaison with the local community mental health teams/psychiatric services.
- Systems were in place to follow up patients at risk of hospital admission and those who had attended accident and emergency.
- Patients were signposted and encouraged to self-refer for psychotherapy services and counselling to improve their mental well-being where appropriate.
- Information about how to access various support groups and voluntary organisations was available to patients.

# Summary of findings

## What people who use the service say

We looked at the most recent national GP patient survey results published in July 2016. A total of 221 survey forms were sent out and 119 patients responded. This represented a 54% response rate from those who were invited to participate, and approximately 3% of the practice's patient list. The results showed the practice was mostly performing below the local and national averages. For example:

- 49% of patients found it easy to get through to this surgery by phone compared to a CCG average of 68% and a national average of 73%.
- 89% of patients said the last appointment they got was convenient compared to the CCG average of 91% and the national average of 92%.
- 70% described their overall experience of the surgery as good, compared against a CCG average of 84% and the national average of 85%.

- 62% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 78% and the national average of 78%.

As part of our inspection we asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 17 comment cards, all of which contained positive feedback about the standard of care received. Patients said they were involved in decisions about their care and described staff as caring, friendly and helpful. Five comment cards contained mixed feedback about the practice relating to difficulties with the appointment system, consultations with GPs, and the environment.

We spoke with two patients during the inspection including the chair of the patient participation group. These patients said they were satisfied with the care and service they had experienced and thought staff were approachable, committed and respectful.

# The Ivy Medical Group

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

## Background to The Ivy Medical Group

The Ivy Medical Group provides medical services to approximately 3,800 patients through a primary medical services contract (PMS). The practice is situated within the Gedling borough to the north-east of the city of Nottingham and serves patients predominantly in the Burton Joyce and Lowdham areas, and the surrounding villages. The practice has two sites with the main surgery being located at Lambley Lane in Burton Joyce, with a branch site at Lowdham Medical Centre. We visited both locations as part of our inspection. A dispensary service is offered from the Lowdham site and about a third of the practice population access this service.

The main site operates from a converted residential property, and the branch site is shared with another local GP practice. All patient services within the practice are provided on the ground floor of the building, whilst the upper floor is utilised for administration.

The level of deprivation within the practice population is significantly below the national average, with most of the practice population living in relatively affluent villages and semi-rural areas on the edge of a large urban conurbation. The practice has the second lowest deprivation score of the 20 practices within NHS Nottingham North and East Clinical Commissioning Group (practice 7.5; CCG 18.1)

The practice team is led by a single-handed male GP who works 30 hours/week. The GP employs a part-time salaried female GP, a full-time practice nurse (female) and a part-time health care assistant (female). The clinicians are supported by a part-time practice manager, a practice administrator, a lead receptionist and a small team of part-time receptionists and medical secretaries. The dispensary staff includes a dispensing manager and a part-time dispensing assistant. Due to the nature of the small practice, some staff have dual roles within the team.

The practice acts as a teaching practice for first and second year medical students from the University of Nottingham medical school.

The practice opens from 8.15am to 1pm (12.30pm at the branch site) and 2pm to 6.30pm Monday to Friday with the exception of Thursday when the practice closes at both sites at 12.30pm. The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Nottinghamshire Emergency Medical Services, who also provide cover when the practice closes on a Thursday afternoon.

## Why we carried out this inspection

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

# Detailed findings

## How we carried out this inspection

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

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

We also looked at how well services were provided for specific groups of people and what good care looked 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 we hold about the practice and asked other organisations to share

what they knew. This included NHS England and Nottingham North and East Clinical Commissioning Group. We carried out an announced visit on 11 April 2017. During our visit we:

- Spoke with a range of staff (including GPs, the practice manager, dispensing staff, the practice nurse, administration and reception staff and a health care assistant).
- Spoke with the chair of the patient participation group and two patients who used the service.
- Observed how patients were being cared for and interactions with staff.
- Reviewed 17 comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed a range of records held by the practice and a sample of the treatment records of patients to corroborate our evidence.

Following our inspection we received written feedback from a range of health professionals working with the practice team. This included the district nurse, care home team lead and the community matron. We also spoke with a health visitor and a manager at a local care home.

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

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place to report, record and analyse significant events and near misses.

- Staff told us they would report any incidents or near misses to the practice manager or GP, and a recording form was completed to inform the investigation. We observed that forms were detailed and signed off when actions had been completed.
- Records reviewed showed 20 significant events had been recorded over the last 12 months and an analysis of each event had been carried out. Near misses were also reviewed in order to learn from issues which could have resulted in an actual incident.
- Findings were discussed at regular meetings and learning had been applied when unintended errors or unplanned events had occurred. For example, additional information had been provided to locum GPs in response to some incidents that had occurred due to the knowledge of internal processes. An annual review of significant events for the period of 2016-17 had taken place in March 2017 to review themes and consider outcomes. Comprehensive minutes were maintained of meetings to evidence these discussions.
- When things went wrong with care or treatment, patients were offered an apology, an explanation and received a review of their health needs.

The arrangement in place for receiving and acting upon patient safety information was robust. All safety alerts, including those from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were recorded on a log which included a link to read the full alert, and detailed the actions that were taken in response to each individual alert. Clinical staff bulletins were also produced to ensure key information was available to all clinicians including locum GPs. We reviewed records to ensure that patients had been reviewed appropriately in response to relevant alerts, and we were assured that the system worked very effectively.

### Overview of safety systems and processes

- Arrangements were in place to safeguard children and vulnerable adults from abuse which reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined who to

contact for further guidance if staff had concerns about a patient's welfare. Staff we spoke to demonstrated they understood their responsibilities to safeguard patients. The GP was the lead member of staff for safeguarding and all staff were aware of this. Training records reviewed showed staff had received up to date training that was relevant to their role, including child safeguarding level three training for the GPs. Regular meetings were also held with the health visitor to discuss children, young people and families at risk of abuse or deteriorating health needs. We spoke with the health visitor who informed us that regular communication took place with the lead GP who was described as very knowledgeable in respect of safeguarding, and responsive to any concerns that were raised.

- Information was displayed in the waiting area and on the practice website advising patients they could request a chaperone, if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy at both sites. The practice nurse was the infection control lead who liaised with the local infection prevention teams to keep up to date with best practice. Infection control audits were undertaken with the most recent audit completed in 2016. An action plan had been formulated to address the improvements needed, and we saw evidence that this has been followed up. There were a range of infection control policies available and most staff had received up to date training including handwashing.
- We reviewed personnel files and found appropriate recruitment checks had been undertaken for staff prior to employment. This included proof of identification, references, qualifications, DBS checks and registration with the appropriate professional body. A system was in place to ensure the practice nurse was registered with the Nursing and Midwifery Council (NMC) and GPs were registered with the General Medical Council (GMC).



# Are services safe?

- However, we observed that two temporary cleaning staff had no information on background checks on file. The practice took immediate action to address this and undertook a risk assessment. The individuals were asked to provide references and the practice agreed to undertake a DBS check if necessary as the cleaners did not have any direct contact with patients.

## Medicines Management

- A dispensing service was offered at the branch surgery for patients who lived more than a mile from their nearest chemist.
- We observed some concerns about the security of the dispensary which was located in shared accommodation with another practice's dispensary. Action had been taken to address security risks in some areas of the dispensary but not in others, for example, unauthorised access by non-practice staff. The practice took immediate action to ensure this area was kept secure and were looking into enhanced security arrangements with the joint occupier and landlord.
- Standard operating procedures (SOPs are written instructions about how to safely dispense medicines) for the dispensary had been recently reviewed. We observed that these were comprehensive and followed in practice.
- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. The practice conducted an annual audit of the dispensing processes.
- Records reviewed showed all members of staff involved in the dispensing process were appropriately qualified and their annual competency checks were undertaken.
- Repeat prescriptions were signed by a GP before they were dispensed and given to patients. Uncollected prescriptions were monitored and followed up if any concerns were raised about individual patients.
- Controlled drug prescriptions were checked with GPs prior to dispensing and prior to the medicine being given to the patient. Suitable arrangements were in place for the storage, recording and destruction of controlled drugs.
- Dispensing near-miss errors were reported and recorded, so that any emerging trends could be identified, monitored and addressed.
- The system to ensure patients who required regular monitoring of their prescribed medicines for potential side effects worked very effectively. A recall system was in place to check these patients had their health needs monitored regularly, and this was overseen by the practice's clinical governance group.
- Signed and up-to-date Patient Group Directions were in place to allow the nurse to administer medicines in line with legislation. The healthcare assistant administered medicines against a patient specific prescription or direction from a prescriber.
- Suitable arrangements were in place to check medicines at both surgeries were within their expiry date and suitable for use. This was done on a monthly basis and all stock we checked was in date.
- The temperatures in the refrigerators at both sites were monitored to ensure medicines were stored within the recommended ranges. Staff were able to describe the actions to take in the event of a fridge failure.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams to ensure prescribing was in line with best practice guidelines for safe prescribing.

## Monitoring risks to patients

- There were procedures in place for monitoring and managing risks to patient and staff safety. For example, the fire risk assessment for both surgeries had been undertaken in July 2016 by an external company. An action plan was developed in response to the areas this identified, and the practice provided us with an update on progress following our inspection. Fire alarm checks were undertaken weekly and fire drills were carried out at least annually, and we saw evidence that firefighting equipment was regularly maintained.
- The practice had service agreements in place to facilitate the checking of all equipment to ensure it was safe to use and working properly. This included fire safety equipment, calibration of medical equipment such as blood pressure monitors, as well as portable appliance testing for small electrical equipment.
- The practice had a variety of other risk assessments in place to monitor the safety of the premises. This included control of substances hazardous to health, health and safety and legionella. Regular monitoring of water temperatures was undertaken and recorded. Legionella is a term for a bacterium which can contaminate water systems in buildings.
- There were some arrangements in place to plan and monitor the number and skill mix of staff needed to



## Are services safe?

meet patients' needs, and this was regularly reviewed by the practice management team. The single-handed GP worked as the assistant clinical lead for the CCG and this meant that the GP was only working in the practice from Monday to Wednesday. The salaried GP worked three sessions per week, but as the practice spanned two sites, the substantive GP provision was insufficient. The provider was actively recruiting for a salaried GP and exploring the introduction of an advanced nurse practitioner role. The practice had also engaged the support of their CCG to assist with recruitment, and were about to embark on a national GP recruitment project with two other local practices as part of the vulnerable practices scheme. The practice was dependent on locum GP cover at the time of our inspection.

- Locum GPs were regularly used to provide support, but the practice tried to use locums they knew to ensure continuity for patients and knowledge of practice systems. A review of capacity was undertaken each week and was a dynamic process to ensure that adequate cover was in place. This was problematic on occasions due to locum availability or sickness, but the practice took action to ensure that they were able to accommodate all urgent needs each day.
- Feedback from some patients suggested there was not always enough GP appointments and reception staff during busy periods. Some non-clinical staff we spoke to

felt on some occasions they would benefit from additional staff due to the workload. The practice was in the process of recruiting support staff for reception and this including an apprentice role at each of the two sites.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to respond to emergencies and major incidents. For example:

- All staff received annual training in basic life support
- Staff had access to an instant messaging system on their computers to alert colleagues to any emergency.
- An automated external defibrillator was available at both premises. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.
- All the emergency medicines we checked were in date and stored securely.
- The practice had oxygen with adult and paediatric masks.
- A first aid kit and accident book were also available.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies of this plan were stored off site. The plan also included back-up arrangements for patients in the rare event that the dispensary was closed.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

- Systems were in place to ensure all clinical staff were kept up to date with published research and guidance, issued by the relevant professional and expert bodies. Practice staff accessed National Institute for Health and Care Excellence (NICE) best practice guidelines and web-based tools providing clinicians access to comprehensive, evidence-based guidance and clinical decision support at the point of care, including clinically and cost effective prescribing.
- The clinicians used a range of audit software tools including risk profiling to assess, review and monitor the health needs of patients with complex long term conditions and those at risk of hospital admission.
- A bi-monthly clinical staff meeting and a quarterly clinical governance meeting ensured regular discussion and updates on clinically based matters. Clinical staff bulletins were produced for all clinicians to share and promote best practice.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results (2015-6) showed the practice had achieved 97.9% of the total number of points available which was marginally above the clinical commissioning group (CCG) average of 95.8% and the national average of 95.3%. The practice were able to provide data (subject to external verification) for 2016-7 which demonstrated this achievement had been maintained at 97.3%.

The published data for 2015-6 showed:

- Performance for mental health related indicators was 98.8% and this was 4.9% above the CCG average and 6% above the national average. The exception reporting rate was higher than both the local and national averages for four out of the six mental health related indicators. The practice's own unverified data for 2016-17 demonstrated the overall achievement for mental health indicators had increased to 100%.

- Performance for dementia related indicators was 100% and this was 2% above the CCG average and 3.4% above the national average. Exception reporting for dementia related indicators was lower than CCG and national averages. A total of 81.8% patients diagnosed with dementia had been reviewed in a face-to-face review in the preceding 12 months. Data for 2016-7 showed the achievement of 100% had been maintained and all patients had received an annual review.
- Performance for diabetes related indicators in 2015-6 was 95.7% and this was 7.5% above the CCG average and 5.9% above the national average. Exception reporting for diabetes related indicators was 16.5%, which was above the CCG and national averages of about 11%. The practice's own data for 2016-7 demonstrated a total of 93% and this was achieved with a reduction in exception reporting to 7.7%
- The practice had a slightly higher prevalence of patients with hypertension than local and national averages. The percentage of patients with hypertension having regular blood pressure tests was 78.8%. This was 5.5% below the CCG average and 4.9% below the national average. The overall exception reporting rate was slightly above local and national averages. The practice's own data for 2016-7 demonstrated an improved achievement of 96%.

The most recently published QOF data for 2015-6 showed the practice's overall clinical exception reporting rate of 11.5% was slightly above the local (8.8%) and national averages (9.8%). Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. The practice had worked hard to successfully reduce their exception reporting rate throughout 2016-7. This had been achieved by a collaborative team approach supported by regular meetings, with a targeted follow up on patients who had not attended for their review. In addition, the practice had undertaken work to maximise the use of their computer software including the introduction of more system prompts to maximise patient engagement and encourage uptake of review appointments, and outstanding checks. The practice's own data for 2016-7 (subject to external verification) which demonstrated that the overall clinical exception reporting rate had fallen to 7.5%.

# Are services effective?

## (for example, treatment is effective)

Clinical audits were regularly undertaken and we saw evidence of improvements made in patient outcomes. For example:

- We reviewed two completed full cycle clinical audits undertaken in the last 12 months. The completed audits focused on improving the treatment of patients with chronic kidney disease (including effective management of their blood pressure levels), and ensuring better anticoagulation rates were achieved to reduce the risk of stroke for patients with atrial fibrillation (an abnormal heart rhythm). Anticoagulants are medicines that help prevent blood clots.
- The practice participated in local audits and peer reviews. For example, the practice had audited outpatient referrals in paediatrics and gynaecology specialities as part of the 'supporting reduction in emergency care' local enhanced service. The audits considered the appropriateness of referrals made by clinicians and attendances by the patients. The findings facilitated in-house patient case discussion amongst the clinical staff and changes where appropriate. Whilst the practice was one of the highest referrers in the CCG, they were able to demonstrate that these had been appropriate and ensured that the patients receive the appropriate care when this was indicated.

Local benchmarking data showed the practice performed better than some local practices in the use of secondary care services by patients. For example, of the 20 practices within the CCG, the practice had the:

- Seventh lowest emergency admission rate
- Second lowest readmission rate within 28 days
- Ninth lowest accident and emergency (A&E) attendance rate
- Second lowest 111 call rate.

The practice provided us with a number of case studies to evidence that this was achieved through the proactive arrangements in place to review patient care and the communication amongst the professionals.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- An induction programme was in place for all newly appointed members of staff. This included an orientation to the practice systems, review of policies, shadowing opportunities and role specific training.
- Staff had access to e-learning modules and face to face training to meet their learning needs and to cover the scope of their work. Training records reviewed showed most staff had completed relevant training including updates, and most other training needs had been identified and planned for. However, training records did not necessarily match the 'mandatory training matrix' produced by the practice which had been sourced from another organisation and not customised to meet the practice's own staffing requirements.
- Staff were allowed protected learning time to enable them to improve their knowledge base.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. They could also demonstrate how they stayed up to date with changes; for example by accessing on line resources, attending refresher training and discussion at practice meetings.
- The development of staff was supported through a system of annual appraisals which promoted their professional development. The appraisals were slightly delayed for the current year due to the absence of a practice manager for several months, but we observed that dates had been arranged for these to take place soon after our inspection. A learning and development plan enabled staff to acquire further skills that were relevant to their roles. For example, one of the reception staff had been supported with additional training to enable them to become a health care assistant, and we saw evidence of how this had evolved. This staff member had recently been trained and assessed for competencies in performing electrocardiograms (ECGs) with support from the practice nurse and GP. An ECG is a test to check the heart's rhythm and electrical activity.
- Dispensary staff were mostly supported to access mandatory and role specific training. For example, one member of staff had completed level two national vocational qualifications in dispensing services. However, one member of the practice team informed us that some training identified to support their role within an appraisal over a year ago had not been addressed.

# Are services effective?

## (for example, treatment is effective)

- Systems were in place to ensure the GPs and the nurse were supported to address their professional development needs for revalidation with the relevant professional body.

### Coordinating patient care and information sharing

Staff could access the information they needed to plan and deliver care through the practice's patient record system and computer system. This included medical records, care plans, and investigation and test results. We observed that record keeping was maintained to a high standard.

The multi-disciplinary team worked together to assess and plan the ongoing care and treatment for patients with complex care needs, and those living in vulnerable circumstance. This included patients receiving end of life/palliative care, people experiencing poor mental health, patients at risk of hospital admission and patients with long term conditions. The monthly meetings were attended by the GPs and members of the practice team with health, social care and voluntary representatives which included district nurses, the care home team, community specialist nurses, a social worker and Age UK. Information relating to the admission, discharge and transfer of patients was shared to ensure the coordination of patients care. Care plans were regularly reviewed and updated.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had received training on this to support their role.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the clinician assessed the patient's capacity and recorded the outcome of the assessment.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. This included patients requiring advice on their diet, exercise, smoking and alcohol cessation.

The practice also encouraged its patients to attend national screening programmes for cervical, bowel and breast cancer. The 2014/15 Public Health England data showed the practice's cancer screening rates were mostly in line or slightly above CCG and national averages. For example:

- 66% of patients between 60 and 69 years had been screened for bowel cancer in the last 30 months (2.5 year) compared to a CCG average of 63% and national average of 58%.
- 85.5% of females aged between 50 and 70 years had been screened for breast cancer in the last three years compared to a CCG average of 79% and national average of 72%.
- 83% of females aged between 25 and 64 years had a record of cervical screening within the target period (3.5 or five year coverage) compared to a CCG average of 86% and national average of 82%.

Immunisation rates for most of the vaccinations given to children were in line with the CCG averages. For example the practice achieved:

- 85% to 100% for all vaccinations given to children under two years old compared to the CCG averages of between 92% and 96.5%.
- 94% to 97% for vaccinations given to five year olds compared to the CCG averages of between 88% and 98%.

The practice had eight patients on their learning disability register, and five of these patients had received an annual health review. The practice explained that the remaining three patients had more complex needs and it was difficult to engage them with the review process. However, the practice were working with the local learning disability nurse specialist to seek solutions to this.

The practice facilitated health checks for new patients and NHS health checks for patients aged 40–74. The number of checks had been low due to staffing capacity, but the practice had identified this as an area of improvement and had worked to improve uptake. We observed that in the previous six month period, 81 patients had been invited to attend a health check and 39 (48%) patients had attended. The practice had added prompts to their computer system to identify appropriate patients, and the health care assistant had established dedicated clinics to deliver the health checks.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were polite and helpful towards patients both at the reception desk and on the telephone. Suitable arrangements were in place to ensure the dignity and privacy of patients was respected. For example:

- Curtains were provided in consulting rooms during examinations, investigations and treatments.
- Conversations taking place between staff and patients in the consultation and treatment rooms could not be overheard because the doors were closed.
- Reception staff could offer a private room to patients who wanted to discuss sensitive issues or appeared distressed.
- Following patient feedback, privacy notices were clearly visible in the reception areas to protect patient confidentiality. We however noted the potential of confidentiality not always being maintained due to the shared reception area with another practice at the branch site at Lowdham.

All of the 17 comment cards we received included positive feedback about the service experienced. Patients said the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. One card included reference to a GP consultation in which the patient felt that some of their issues had not been listened to or responded to, although other aspects of their care had been effectively dealt with.

We spoke with the chair of the patient participation group (PPG) who praised the practice staff. The chairperson told us they were highly satisfied with the care provided by the practice and said their dignity and privacy of patients was always respected.

The national GP patient survey results showed that the practice was mostly below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 81% of patients said the last GP they saw or spoke to was good at listening to them compared to the clinical commissioning group (CCG) and national average of 89%.

- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and the national average of 85%.
- 81% of patients said the nurse was good at listening to them compared to the CCG and the national average of 91%.
- 93% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 78% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 91%.

In addition, 82% of patients found the receptionists at this surgery helpful compared against a CCG average of 87% and a national average of 87%.

The practice team and PPG were aware of the lower national patient satisfaction scores and had identified an action plan in response to the patient feedback in order to drive improvements in patient experience; for example, by upgrading the telephone system. The practice's undertook an internal annual survey undertaken during November to December 2015 showed a higher number of patients were satisfied with the care received. For example:

- 91% of the 288 patients who responded rated the service received from reception staff as excellent or good, whilst 6% of patients rated it as fair.
- 87.5% of patients surveyed rated the care received from doctors and nurses as excellent or good; whilst 8% of patients rated it as fair.

At the time of our inspection, the practice had completed a further annual patient survey and had analysed feedback with their PPG in April 2017. This included feedback on how patients rated privacy within the reception area.

- 56% of the 258 patients who responded rated this as good or excellent. This aligned with the practice's plan to re-develop their premises to improve the layout of the environment.

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



## Are services caring?

The practice facilitated advance care planning with patients who had complex health needs, working alongside relatives/carers and health and care professionals in the wider community. This included people with dementia and those approaching their end of life. Patients receiving end of life care had their information recorded in the electronic palliative care co-ordination systems (EPaCCS), to ensure their care was delivered in line with their care preferences and shared appropriately with services such as the out of hours provider when the surgery was closed.

Patient feedback on the comment cards we received showed most patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. However, results from the national GP patient survey results were mostly lower than local and national averages for consultations with GPs and nurses. For example:

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 73% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.
- 77% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

Staff told us that translation services were available for patients who did not have English as a first language and this enabled patients to be involved in decisions about their care.

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had a staff member designated as the carers' champion and a register of carers was maintained. The practice had identified 85 patients as carers and this represented 2.2% of the practice list. A carer's information pack was available to direct carers to the services and support available to them.

When families had suffered bereavement, a letter was sent with condolences and the offer of support dependent on individual need. As a small practice, the practice team knew their patients well and were able to provide personalised care to their patients and families.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice was working with their CCG and two other local practices on a recruitment campaign for GPs.
- A range of services were offered in the practice to reduce the need for patients to travel in order to access services. These included family planning, phlebotomy, ambulatory blood pressure monitoring, spirometry and abdominal aortic aneurysm (AAA) screening for men aged 65 and over. AAA is a way of detecting a dangerous swelling (aneurysm) of the aorta, the main blood vessel that runs from the heart, down through the abdomen to the rest of the body.
- Patients at risk of hypertension had access to "Flo" (a telehealth text messaging service) which enabled them to monitor and improve the management of their blood pressure levels and reduce the need for face-to-face consultations with a clinician.
- The practice provided phlebotomy, and this included visiting patients at home. The visits were above their specified contractual requirement.
- The practice participated in the CCG locality care delivery group pilot scheme to ensure integrated care for older people. Outcomes included the practice staff having named professionals (social worker and community officer) they could make referrals to for older people, to receive an assessment of their social care needs.
- The practice provided a dispensary service at their branch site at Lowdham for approximately one third of their registered patients. A medicines delivery service was offered to housebound patients who had their medicines dispensed by the practice. This aided rapid access to medicines for patients residing across the local rural area. However, we were informed that on occasions of staff shortages, patients would be directed to a pharmacy as the dispensing assistant had to cover reception.
- The dispensary staff offered monitored dosage systems for patients who needed this type of support to ensure they took their medicines correctly.
- Patients living in vulnerable circumstances and those with complex health needs were given a priority number to enable them to access immediate care when needed. This included those patients receiving end of life care and experiencing poor mental health. Effective systems were in place to ensure all staff were fully aware of these patients to facilitate a responsive service.
- The practice participated in the 'one care home, one practice scheme' which aligned the practice to a local care home. This ensured more proactive care for residents including two weekly ward rounds, and an annual health and medicines review. All new residents received a medical examination, and the practice team worked with care home staff to avoid admissions by advance care planning.
- The practice had mostly good facilities and was well equipped to treat patients and meet their needs, although the practice were mindful that both sites required modernisation. The branch site did not have adequate signage to enable clear distinction between it and the practice which shared the same building. The need to enhance facilities and the environment was reflected in the practice business plan and options were under consideration as to how this could be achieved.
- There was a proactive approach to improving information technology resources for the benefit of patients. For example, the practice website included links to extensive health promotion information and healthy living advice to improve patient education.
- The practice had developed an iPhone application which allowed patients to:
  - have easy access to online appointments and repeat prescription requests.
  - stay up to date with news and twitter timeline feeds.
  - use the mapping services to navigate to the surgeries.
- Longer and flexible appointments were offered for patients with a learning disability, new patient health checks and people with complex long term conditions.
- Patients who had clinical needs which resulted in difficulty attending the practice and older patients including those residing in care homes could request a home visit.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice were working with Age UK to introduce 'tea mornings' on site for older and vulnerable patients to develop social inclusion and to provide an opportunity to review individual needs.

### Access to the service

The practice was open at both surgeries from 8.15am until 1pm (main site, 12.30pm at the branch site) and from 2pm to 6.30pm on Monday, Tuesday, Wednesday and Friday. Opening hours on a Thursday were from 8.15am to 12.30pm.

Generally, GP appointments were from 8.30am to 11am every morning and 4pm to 6pm every afternoon with the exception of Thursdays. On the day of the inspection, the next GP appointment was available in three weeks, but we were informed by staff that this was usually between one to two weeks. However, patients could ring back when more appointments were released or became available due to cancellations, for example. Pre-bookable appointments could normally be booked up to four weeks in advance, although on the day of our inspection, this had increased to six weeks. Urgent appointment requests were triaged by a GP and patients were accommodated on the same day if appropriate. Telephone consultations were available with the GP, and these would be done on the same day whenever necessary.

Winter pressure funding from the CCG had increased appointment capacity between February and April 2017.

Patient feedback from the national GP patient survey results indicated that access was mostly below local and England averages. For example:

- 49% of patients found it easy to get through to this surgery by phone compared to a CCG average of 68% and a national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 84% and a national average of 85%.
- 58% of patients described their experience of making an appointment as good compared to a CCG average of 69% and a national average of 73%.
- 40% of patients usually got to see or speak to their preferred GP, compared to the CCG average of 52% and the national average of 59%.
- 61% of patients were satisfied with the practice's opening hours compared to the CCG and national averages of 76%.

- 70% usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 63% and the national average of 65%.

The practice team were aware of the lower satisfaction rates, and improvement work had been undertaken with the patient participation group (PPG) to improve the patient experience of accessing the service. For example, the telephone system had been upgraded in January 2016 following patient feedback and involvement from the PPG.

The latest internal patient survey in April 2017 showed:

- 65.7% of the 258 patients surveyed described the new telephone system as excellent or good, whilst 23% described it as fair. A further 15 patients described this as poor, whilst the remaining patients surveyed did not provide an answer.
- 55.5% of patients described the ability in making an appointment as excellent or good, whilst 33% said it was fair.

### Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.
- Patients we spoke with told us they had not had cause to complain but would be confident in accessing the relevant information should they require this.

We looked at eight complaints received in the last 12 months and found that they had been acknowledged and responded to in a timely way. The practice investigated complaints and apologies were offered where appropriate. Lessons were learnt from individual concerns and complaints, and action was taken as a result to improve the quality of care. An annual review of complaints involving all clinical staff and non-clinical leads was held to review any themes that had occurred in relation to the complaints received. For example, a trend was identified in respect of locum GPs which resulted in the locum induction pack being updated and information on learning from complaints being shared with the locums.



# Are services well-led?

Requires improvement 

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

## Our findings

### Vision and strategy

The practice had a vision to provide the best primary medical services with a focus on family health and continuity of care. The practice had developed clear aims and objectives, and these were displayed in the waiting areas, practice website and patient leaflet.

- The practice values focussed on adopting a caring and transparent approach, collaborative working, the adoption of high standards, and providing the best possible patient care. Not all of the staff we spoke with were able to demonstrate an understanding of the values and how they implemented them in their day to day work.
- The practice had a supporting business plan which took account of its strengths, weaknesses, opportunities and threats to inform its strategy for the next five years. This included strong patient engagement with support from the patient participation group (PPG) and challenges related to delivering primary medical services over two sites.

### Governance arrangements

- There were some systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of staff and patients. Not all areas of risk had been considered with appropriate measures of control being implemented. However, following our inspection the provider informed us of actions they had taken to rectify the issues highlighted to them. For example, security enhancements within the dispensary.
- The practice had a clear staffing structure and staff were aware of their roles and responsibilities. Clinicians had lead roles for specific health matters and acted as a resource for their colleagues. For example, the GP principal led on rheumatology and the salaried GP had a specialist interest in women's health.
- There was a clear understanding of the practice's clinical performance and this was positively reflected in the benchmarking and quality outcomes framework data.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. Patient outcomes and referral activities were reviewed regularly.

- A network of meeting supported governance arrangements. This included a weekly practice management meeting, a bi-monthly clinical meeting and a quarterly clinical governance meeting. We saw that comprehensive notes were maintained for all meetings providing clear evidence of discussions and actions taken.
- A wide range of practice specific policies and protocols were in place and accessible to all staff.

### Leadership and culture

There was a clear leadership structure in place and staff felt supported by management. The practice had recently changed its legal status from a partnership to that of a single-handed GP. Shortly after this, the practice manager had left the surgery and there had been a period of several months without a substantive practice manager appointment, although temporary expert advice had been contracted via two independent practice managers. A new practice manager had commenced employment with the practice two weeks prior to our inspection which would provide dedicated management support to the practice. The absence of dedicated practice manager support had meant that some of the oversight of processes including staff appraisals, training, and completion of action plans was not always fully effective.

The lead GP was the assistant clinical lead for the CCG, which produced benefits for the practice and ensured they were at the forefront of new developments. However, this commitment meant that the GP did not provide consultations at the practice for two days each week. The national GP survey demonstrated that 40% of patients usually got to see or speak to their preferred GP, compared to the CCG average of 52% and the national average of 59%. There was an ongoing reliance upon locum GPs due to a long-standing salaried GP position for 7-8 sessions each week. The oversight of locums was variable, and we saw that a number of the significant events and complaints related to locums. We also observed that there had been occasions when the practice had not been able to cover all GP sessions due to the sickness or unavailability of locums. This was reflected in patient survey results which demonstrated that the practice performed less favourably than local and national averages with regards access to appointments. Additionally, we observed that reception

# Are services well-led?

Requires improvement 

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

staff were constantly busy and participated in many tasks. The provider was in the process of recruiting more staff but we identified that this was a long-standing issue which had not been adequately addressed.

The practice worked with other local GP practices and had developed some federative working, recognising the benefits of collaborative working. Strong links were established with a neighbouring practice and plans for more formalised integration for the future were under consideration.

Staff told us that the GP was approachable and encouraged a culture of openness and honesty.

- Staff we spoke with felt communication within the practice was good and this included use of notifications within the clinical system and meetings. For example, team meetings were held that involved the whole staff team which ensured staff were kept up to date with relevant information and were provided an opportunity to raise any issues. Whilst these meetings were scheduled to take place every six months, ad hoc meetings were arranged in-between as required, and the practice had designated learning time each month which provided a further opportunity for discussions.
- Staff told us they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and were encouraged to identify opportunities to improve the service delivered by the practice. However, some staff identified that their role would be improved with greater staffing capacity.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice gathered feedback from patients through the PPG, friends and family test results, a suggestion box, and their own internal patient survey.
- The most recent practice survey had been undertaken in March and April 2017 and the practice were in the process of analysing these results and formulating an action plan. Patients had been invited to provide comments on areas for improvement in the next six months as part of this survey. The feedback aligned with

the areas already recognised as key issues by the practice, predominantly workforce and premises, which the practice had incorporated into their business planning strategy. However, the questions used in repeated surveys was not consistent and did not follow the same format as the national questionnaire. As such, it was difficult to benchmark and monitor the impact of changes over time.

- The practice had a well-engaged PPG which influenced practice development. The PPG consisted of eleven active members and met approximately every two months, and the GP would attend this meeting. They made suggestions for improvements to the practice. For example, the group had supported the implementation of a new telephone system, and initiated a system to monitor equipment on loan to patients. Additionally the practice involved the PPG in discussions about the redevelopment of the branch site at Lowdham. The PPG chair spoke very positively about the leadership and engagement work with the practice team. The PPG had a dedicated notice board in the waiting area, and periodically produced a patient newsletter. The PPG also informed patients of activities within the practice by having a notice in the local Parish magazine.

## Continuous improvement

The practice team took account of the NHS five year forward view in developing their services. The view sets out a vision for the future of the NHS, and describes a range of new ways of breaking down the traditional divide between primary care, community services and hospitals.

For example, the practice participated in new models of care and local pilot schemes, so as to improve integrated care and outcomes for patients in the local area.

The practice was a founding member of the Nottingham North and East Community Alliance (NNECA), which comprised of four GP practices. The group was involved in the Primary Care Home project to enable primary care, community health and social care professionals to work in partnership with specialists to provide out of hospital care. The priorities included improving mental health, reducing emergency admissions, facilitating discharge, enhancing access, maximising technology around integrated care delivery and supporting self-care.

# Are services well-led?

Requires improvement 

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

The Ivy Medical Group acted as a teaching practice for first and second year medical students from the University of Nottingham medical school. The practice was also working towards developing the practice to facilitate GP training in 2018/19.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>The registered provider must:</b></p> <p>Strengthen the systems to enable the provider to have effective oversight of the quality of the service being delivered and to mitigate identifiable risk. For example by ensuring the ongoing oversight of locum GP work; reviewing clinical and non-clinical staffing capacity; considering all risk areas with appropriate control measures being instigated and monitored.</p>
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	