Castle Healthcare 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Castle Healthcare Practice on 22 September 2015. Overall the practice is rated as good.

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

- We inspected the practice within 11 months of being registered with the Care Quality Commission and found significant achievements had been made within a short time to provide a responsive and patient focused service.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice used proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, they had a robust and patient focussed approach to reviewing the health needs of older people, patients on high risk medicines and people experiencing poor mental health.
- 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 said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Urgent appointments were usually available on the day they were requested. However, patient feedback was mixed in respect of telephone access, availability of routine appointments and waiting times.

Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice had excellent facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. The strategy and business plans to deliver this vision were regularly reviewed and discussed with staff.
- There was a clear leadership structure and staff felt supported by management. High standards were promoted across all roles.

An area of outstanding practice:

- The patient participation group promoted short walks on most Tuesdays leaving the surgery waiting area at 10.30am and again at 11.30am. This was aimed at promoting activity for people who may not otherwise go out for a walk alone and to create friendship opportunities.

However there were areas where the provider should make improvements:

- Improve multi-disciplinary working and communication to ensure patients receive timely and well-coordinated care.
- Improve processes for making appointments including the availability of non-urgent appointments and reducing waiting times.
- Take steps to improve the number of annual health checks undertaken for people with learning disabilities.

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.

The practice had an open and transparent culture towards safety and an effective system for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Information about safety was highly valued and used to promote learning and improvement.

There were suitable arrangements in place to keep people safe and safeguarded from abuse. Medicines were well managed and the monitoring of high risk drugs was a strong feature. Risks to people using the service were assessed and well managed. The practice had procedures in place for dealing with emergencies, including dedicated rooms for medical emergencies.

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 (NICE) guidelines and other locally agreed guidelines. We saw evidence to confirm that these guidelines and clinical audits were positively influencing and improving patient outcomes and practice performance.

The 2014/15 data showed mixed patient outcomes, with most clinical indicators at or above average for the locality. The practice had action plans in place to address areas where performance was not in line with national or local figures.

The practice worked in collaboration with other health and social care professionals. However improvements were required to ensure effective multi-disciplinary working, communication and the regular review of patients' needs.

A strong feature of the practice was the strategic and proactive engagement to address the health and well-being of patients within the community. For example, one of the GP partners had contributed to the establishment of the weight management service and the design of referral forms which are used by GP's within the local area. The practice had referred 120 patients to date and 368 patients were receiving support in weight management within Nottinghamshire.

Summary of findings

The patient participation group also promoted short walks on most Tuesdays leaving the surgery waiting area at 10.30am and at 11.30am. This was an outstanding feature which promoted activity for people who may not otherwise go out for a walk alone and created friendship opportunities.

Are services caring?

Good

The practice is rated as good for providing caring services.

Most patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Some patients gave specific positive examples to demonstrate how their choices and preferences were valued and acted on.

This was aligned with patient survey data which showed the practice had comparable rates to the local and national averages for its consultations with GP and nurses.

We observed a patient-centred culture with staff committed to improving patient's experience of the service. The practice had systems in place to support patients cope with their care and treatment. This included a clinical commissioning group (CCG) led bespoke carers service and information relating to support groups and bereavement.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice was actively engaged work with the local community in planning and developing innovative approaches to ensure integrated and person-centred care. This included care for older people living in care homes and those considered frail; and patients experiencing poor mental health. This was led by the GP partners who held strategic roles within the clinical commissioning group.

Patient feedback about access to the service was mixed. For example urgent appointments were usually available on the day they were requested. However, patients said that they sometimes had to wait a long time for non-urgent appointments and access to a named GP.

This was aligned with the national patient survey results published in July 2015 which showed:

- 74% of respondents described their experience of making an appointment as good compared to a local average of 80% and national average of 73%.

Summary of findings

- 39% of respondents did not find it easy to get through by phone compared to a local average of 19% and national average of 27%.

The practice had implemented improvements to monitor telephone access, availability of appointments and waiting times as a consequence of patient feedback.

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

Are services well-led?

Good

The practice is rated as good 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 patients, stakeholders and was regularly reviewed and discussed with staff. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management. High standards were promoted and owned by all practice staff and teams worked together across all roles. There was an overarching governance framework which supported the delivery of the strategy and good quality care.

Governance and performance management arrangements were proactively reviewed and took account of current models of best practice. There was a strong focus on continuous learning, innovation and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The leadership of the practice had a thorough understanding of the needs of older people and were engaging this patient group and other stakeholders to improve the service. Specifically,

- One of the GP leads was the clinical commission group (CCG) lead for the enhanced care home service provision which aimed to improve the quality of care for older people by reducing unplanned admissions, ambulance transfers, length of inpatient stays and falls. Data reviewed showed positive outcomes had been achieved and this included reduced hospital admissions from nursing homes within the local area.
- The practice offered proactive, personalised care to meet the needs of the older people in its population. Weekly visits were carried out by dedicated GPs for three local care homes to ensure continuity of care. Joint visits were also undertaken with a pharmacist advisor to review the medication of the residents.
- Another GP was the CCG lead for frail elderly persons and within their role they had facilitated the implementation of the carer support service offered within the local area and joint working arrangements with the community geriatrician.

The practice offered proactive and personalised care to meet the needs of the older people in its population. Home visits and urgent appointments for patients with enhanced needs were available when needed. Patients aged 75 and over had a named GP.

Some areas requiring strengthening included:

- Outcomes for patients diagnosed with Osteoporosis. For example, 66.7% of people aged over 75 with a fragility fracture were being treated with a bone-sparing agent compared to a CCG average of 78.6% and national average of 79.3%.

People with long term conditions

Good

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

Nationally reported data showed outcomes for patients with long term conditions were mostly in line with and or above the local and national averages. This was achieved through:

Summary of findings

- Effective systems in place to assess, review and monitor the outcomes for patients. The GPs and nursing staff had lead roles in chronic disease management and the monitoring of patient outcomes.
- Patients at risk of hospital admission were identified as a priority and suitable care planning arrangements were in place to reduce avoidable admissions.
- Regular and structured reviews were undertaken to check that patient's health and needs were met and their medicines remain suitable. The named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care for people with the most complex needs. However, improvements to multi-disciplinary arrangements were required to ensure all patients received timely and coordinated care.
- Longer appointments and home visits were available when needed.

Families, children and young people

Good

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

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.

There were systems in place to safeguard children from abuse and to follow up children living in disadvantaged circumstances. Joint working arrangements were in place with midwives, health visitors and school nurses. However these needed to be strengthened to ensure effective communication and coordination of patients care. Immunisation rates were relatively high for all standard childhood immunisations.

The practice offered responsive services to young people. This included engagement with sixth form students at a local school, teenage immunisations and being signed up to the C-Card scheme. This scheme offers one to one consultation for young people aged 13 –24 to get free condoms and advice about sex and relationships.

One of the GPs also had a special interest in teenage health and worked as a school doctor and shared their expertise with staff. Another GP had initiated the Public Health adolescent strategy within the local area; and this included reducing obesity.

Summary of findings

Working age people (including those recently retired and students)

Good

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

A strong feature of the practice was the strategic work related to health and well-being. For example, one of the GP executive partners was the clinical commissioning group (CCG) lead for the health and wellbeing board and a member of the obesity steering group. They had contributed to the design of referral forms for patients to receive support with weight management; and these were used by GPs within the CCG area.

The practice was instrumental in the establishment of this service which is commissioned by Public Health. The practice had referred 120 patients to date and 368 patients were receiving the weight management services within Nottinghamshire.

The patient participation group (PPG) also promoted short walks on most Tuesdays leaving the surgery waiting area at 10.30am and again at 11.30am. This was aimed at promoting activity for people who may not otherwise go out for a walk alone and to create friendship opportunities.

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. For example,

- patients could access appointments and telephone consultations between 8am and 8pm Monday to Friday; and urgent appointments on a Saturday and Sunday morning from another local practice.
- engagement with patients via text messaging with their consent and
- access to both female and male GPs.

The practice was proactive in offering online services and this included booking appointments and ordering repeat prescriptions. A full range of health checks, screening programmes and health promotion advice was offered.

People whose circumstances may make them vulnerable

Good

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

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

Summary of findings

how to contact relevant agencies in normal working hours and out of hours. The practice worked with multi-disciplinary teams in the case management of vulnerable people; and improvements were needed to improve communication and coordination of care.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability and patients receiving palliative care. It offered annual health checks for people with a learning disability. However, follow-up of these patients needed strengthening to ensure attendance.

The practice premises were new and purpose built with reasonable adjustments made for people with disabilities and impairments. For example, braille signage, hearing loop; automated doors and adjustable beds. Vulnerable patients had access to information on various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Good

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

The practice regularly worked with multi-disciplinary teams in the case management and care planning of people experiencing poor mental health and those with dementia. Patients and or their carers were informed about how to access various support groups and voluntary organisations.

The practice had 148 patients listed on their dementia register. Data showed 85.2% of people had their care reviewed in a face to face meeting within the last 12 months.

A system was in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Robust systems were in place for the in house drug monitoring of high risk medicines such as lithium and clozapine. The practice had lower than local average rates for anti-depressant prescribing.

Staff had a good understanding of how to support people with mental health needs and dementia. They were supported by one of the GP partners who was the clinical commissioning group lead for mental health. They had a strategic overview of local mental health service provision and led on development work to improve patient care.

Summary of findings

What people who use the service say

As part of our inspection we asked for CQC comment cards to be completed by patients. We received 18 comment cards which were mostly positive about the standard of care received. Patients said staff were very empathic and helpful; with some patients naming specific GPs and nurses they felt had provided excellent care. They felt listened to and involved in decisions about their care. Specific examples were also given of prompt action taken to follow-up patient's individual care needs and make appropriate referrals.

We spoke with 13 patients during the inspection including four members of 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. Most patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

They praised the facilities within the new purpose built premises although some patients felt its location meant further travel from home and the lift did not always work. Less positive comments related to telephone access, availability of routine appointments and waiting times to be seen by a clinician.

The results of the national GP patient survey published in July 2015 showed the practice was performing below or in line with the local and national averages. There were 250 survey forms distributed and 105 were returned representing a 42% completion rate.

- 85% described their overall experience of this surgery as good compared to a clinical commissioning group (CCG) average of 90% and a national average of 85%.
- 85% found the receptionists at this surgery helpful compared to a CCG average of 91% and a national average of 87%.
- 72% would recommend this surgery to someone new to the area compared to a CCG average of 83% and a national average of 78%.
- 74% described their experience of making an appointment as good compared to a CCG average of 80% and a national average of 73%.
- 44% usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 64% and a national average of 65%.

61% found it easy to get through to this surgery by phone compared to a CCG average of 81% and a national average of 73%.

Areas for improvement

Action the service SHOULD take to improve

- Improve multi-disciplinary working and communication to ensure patients receive timely and well-coordinated care.
- Improve processes for making appointments including the availability of non-urgent appointments and reducing waiting times.
- Take steps to improve the number of annual health checks undertaken for people with learning disabilities.

Outstanding practice

- The patient participation group promoted short walks on most Tuesdays leaving the surgery waiting area at 10.30am and again at 11.30am. This was aimed at promoting activity for people who may not otherwise go out for a walk alone and to create friendship opportunities.

Castle Healthcare Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a second CQC Inspector, two GP specialist advisors, a practice nurse specialist advisor and a practice manager specialist advisor.

Background to Castle Healthcare Practice

Castle Healthcare Practice is a merger of Ludlow Hill Surgery, Trent Bridge Medical Practice, Compton Acres Medical Centre and Southview Surgery, which opened on 13 October 2014. It is located on Wilford Lane in West Bridgford, an area of Nottinghamshire.

A free bus service to the practice is available between 8am and 4.30pm Monday to Friday. This was funded by the practices as part of the development and relocation.

Services are provided from a purpose built primary care centre co-located with another GP practice, a (with an extended 100 hour licence) and physiotherapy service. There are also extended services co-located with Castle Healthcare Practice such as weekly access to an ultra-sound service, diabetic retinopathy, telephone dermatology and abdominal aortic aneurysm (AAA) screening.

The practice had a patient list size of 17642 at the time of our inspection. The practice holds a Personal Medical Services (PMS) contract to provide GP services which are commissioned by NHS England and Rushcliffe Clinical Commissioning Group (CCG).

The practice employs a total of 66 staff and the organisational structure includes:

- Three executive GP partners (management, financial and human resources)
- Seven GP partners, a salaried GP and a consultant in primary care.
- One nurse manager, two nurse prescribers, six nurses, three healthcare assistants and two phlebotomists.
- One business manager and a financial administrator
- One reception duty manager and a team of 17 receptionists
- A practice manager and IT systems manager
- A senior secretary and three secretaries
- Three members of staff undertaking note summarising and data entry; and an administrator.

Castle Healthcare Practice is a training practice and is accredited as research ready by the Royal College Of General Practitioners. There was one GP trainee placed at the time of our inspection.

The practice is open 8am to 8pm Monday to Friday, beyond its PMS and extended hours contracted commitment. Patients have access to GPs, nursing staff and the reception team during these hours.

Patients with urgent health care needs can access appointments on Saturday and Sunday mornings between 8.30am and 12.30pm. This service is provided from another local practice and Castle Healthcare practice participates in the CCG-led weekend service.

When the practice is closed patients are directed to the out of hours' service provided by Nottingham Emergency Medical Services at (NEMS) via the 111 service.

Detailed findings

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. 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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- 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. This included engagement with NHS England, Rushcliffe clinical commissioning group (CCG) and Healthwatch.

We carried out an announced visit on 22 September 2015 and spoke with a range of staff including:

- GPs, a registrar, a nurse manager, practice nurses and a health care assistant
- The business manager, duty reception manager and a range of administration, reception and secretarial staff
- Community matron, district nurse, health visitor
- Carers Federation adult carers support worker

We spoke with 13 patients including four members of the patient participation group (PPG). We observed how people were being cared for and talked with carers and/or family members. We also reviewed the personal care or treatment records of patients and comment cards where patients shared their views and experiences of the service.

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting, recording and responding to safety concerns. This included 13 significant events recorded to date, national patient safety alerts as well as comments and complaints received from patients.

Feedback from staff and records reviewed showed the whole practice team was engaged in reviewing and improving safety. For example, the leadership had a robust picture of all safety concerns raised and these were discussed in detail at the individual staff group meetings for GPs, nurses and non-clinical staff. Records reviewed showed:

- the practice carried out a thorough analysis of the significant events; although some forms were not completely filled in and / or signed off by the person accepting responsibility for any necessary changes.
- lessons were identified and shared with staff to ensure action was taken to improve patient safety. This included updating of relevant policies to ensure staff were following best practice guidelines.
- where appropriate, reviews were undertaken and / or individual discussions were held with concerned staff to ensure sustained improvements were made.

Staff also told us that all safety concerns were prioritised and viewed as integral to learning and improvement; and this was achieved through an open and transparent culture where safety concerns were discussed.

Some patient safety incidents were reported externally via the National Reporting and Learning System (NRLS). The NRLS enables patient safety incident reports to be submitted to a national database. This provides the opportunity to ensure that the learning gained from the experience of a patient in one part of the country is used to reduce the risk of something similar occurring elsewhere.

We saw documented examples of when individual patients received an apology when there was an unintended or unexpected safety incident. They were also told about the actions taken to address the concern and improvements made to prevent the same thing happening again.

Overview of safety systems and processes

The practice had suitable arrangements in place to keep people safe. This included:

Safeguarding people who use services from abuse

The practice had designated safeguarding leads for children and vulnerable adults; and they took leadership responsibility for the practice's safeguarding arrangements. The safeguarding policies we reviewed reflected relevant legislation and local guidance; and these were accessible to staff. Staff we spoke with knew what to do when safeguarding concerns were raised and all had received training relevant to their role. This included GPs being trained to safeguarding level three for children.

Safeguarding information was visually displayed for staff and safeguarding referrals were made to the multi-agency safeguarding hub (MASH) as appropriate.

Fortnightly multi-disciplinary meetings were held with the midwife and health visitor to discuss at risk children and families; and to agree follow-up action to safeguard them. Feedback received from the midwife and health visitor showed improvements could be made to ensure that the GPs who attended these meetings had some knowledge of the patients and / or provided detailed information on their wellbeing during the meetings.

Patients had access to a chaperone if required. Nurses and healthcare assistants acted as chaperones and records reviewed showed they were trained for the role, understood their responsibilities and had received a disclosure and barring check (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.

Medicines management

The practice had robust arrangements in place to ensure the safe and effective use of medicines, emergency drugs and vaccinations; as well as the best possible outcomes for patients (medicines optimisation). This included policies and procedures for obtaining, recording, handling, storing and the security of medicines.

- Medicines reviews for patients living in care homes was jointly undertaken by the GPs and the clinical commissioning group (CCG) pharmacist; with evidence of improved medicine management in respect of wound care and sip feeds.

Good

Are services safe?

- The practice had a lead GP for prescribing and regular medicines audits were carried out to ensure prescribing was in line with best practice guidelines. For example, audits completed related to controlled drugs and antibiotic prescribing. Records reviewed showed the audit outcomes were discussed at clinical meetings and up to date guidelines were disseminated.
- Patient Group Directions had been adopted by the practice to allow practice nurses to administer medicines in line with legislation.
- Prescription pads were securely stored and systems were in place to monitor their use. However, we noted that a protocol was not in place for ensuring the regular review of uncollected scripts.
- A few patients told us that when the practice initially opened there were delays in the processing of acute or repeat prescriptions. Additionally, the district nurses reported some delays in the processing of prescriptions for dressings. However, they felt some improvements had been made.
- The practice was responsive to safety alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) and European Medicines Agency (EMA). However, the practice's search folders which were brought forward from all four practices had not yet been reorganised to schedule regular reruns and ensure that patients had not been inadvertently prescribed medicines considered unsafe by MHRA.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We observed the premises to be clean and tidy.

The nurse manager was the infection control clinical lead. They were supported in completing the practice's initial audit on 3 July 2015 by the NHS England infection control matron.

The audit showed appropriate standards of cleanliness and hygiene had mostly been maintained and we saw that action was taken to address any improvements identified as a result. This included updating of policies, providing staff training and improving cleaning standards.

Equipment

Staff we spoke with told us they had the equipment they required to enable them to carry out diagnostic examinations, assessments and treatments. Portable electrical equipment was tested to ensure they were safe to use and clinical equipment was calibrated to ensure it was working properly.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All the staff files that we looked at contained evidence of appropriate recruitment checks that had been undertaken prior to employment. This included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

The practice had appropriate management structures in place to ensure that patients were cared for by sufficient numbers of staff with the right, knowledge, skills and experience. For example;

- One of the executive GP partners was the lead for human resources; and their strategic role included: overseeing the interview and appointment of staff and managing poor performance. They spoke positively about how the leadership team had prioritised the staffing requirements of the practice and the future need to develop staff potential through learning and continuous development opportunities.
- The resulting outcome was staff engagement and satisfaction, which was crucial to the leadership to ensure a productive workforce and good service delivery.
- At the time of our inspection there were 66 staff members. All the staff we spoke with told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.
- Records reviewed showed a needs analysis and risk assessment was considered as basis for deciding sufficient staffing levels staff.
- The business manager showed us records including staff rotas to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Good

Are services safe?

- Suitable arrangements were in place to cover staff absences, sickness and emergencies. This included an in-house cover system and use of locum GPs as a last resort. Some staff worked part time which also gave the flexibility to cover colleagues.

Monitoring safety and responding to risk

A substantial amount of time and resources had been invested in designing the layout of the premises to ensure compliance with legal requirements relating to the premises. In addition, effective systems were in place for assessing, monitoring and managing risks to patients and staff safety. These included:

- a variety of up to date risk assessments and regular safety checks of the building and environment. For example, the control of substances hazardous to health and legionella.
- staff being provided with health and safety training and relevant guidance to mitigate identified risks.
- the fire alarm was tested weekly and staff were fully aware of the evacuation procedures.

Arrangements to deal with emergencies and major incidents

The practice had suitable arrangements in place to respond to emergencies and major incidents.

- The practice had two dedicated emergency rooms in which emergency medicines and equipment were securely stored and easily accessible to staff. This included a defibrillator and oxygen with adult and children's masks. All the emergency medicines we checked were in date and fit for use.
- Staff told us the use of dedicated rooms ensured an efficient and well-coordinated response to medical emergencies; and also protected the concerned person's privacy and dignity. Additionally, the layout of the building included a quick exit route for transferring critically ill patients to hospital.
- Two significant events related to medical emergencies showed staff had responded appropriately to ensure the patient and visitor received safe care and treatment.
- Life support guidance was displayed in all rooms and a cardiac arrest bag was available on each floor of the building.
- There was an instant messaging system on the computers and safety buttons on the wall which alerted staff to any emergency.
- All staff had received annual basic life or cardio pulmonary resuscitation training.
- The practice had a comprehensive 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 were also kept securely offsite.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with told us they were involved in the assessment of their needs and their preferences and choices were considered in the planning of their care. Records reviewed and staff we spoke with confirmed that patients' needs were assessed and delivered in line with relevant and current evidence based guidance and standards. This included use of National Institute for Health and Care Excellence (NICE) best practice guidelines and the Nottinghamshire guidelines on the management of common infections.

The practice had effective systems in place to ensure all clinical staff were using up to date information to deliver care and treatment that met people's needs. For example:

- One of the GPs had been involved in the development of new guidelines for a number of ear, nose and throat conditions and these had been reviewed by secondary care consultants and were in use in the practice.
- An in-house monthly education programme to look at relevant NICE guidelines was in place. The GP lead for education disseminated clinical information to staff; and all clinicians had access to them including web based resources.
- Clinical meetings for GPs and nurses were held and best practice guidelines were discussed. The practice monitored that these guidelines were followed through risk assessments and audits.
- GP trainees and foundation year (F2) doctors attended daily debrief meetings to review the care needs of patients allocated to them.
- Some of the GP partners had strategic roles within the clinical commissioning group (CCG) and promoted the implementation of up to date assessment tools to aid the diagnosis of specific conditions such as dementia. They were supported by the IT systems manager in developing relevant templates to ensure consistency in patient information gathered.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. 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.

Castle Healthcare Practice is a partnership, which was made up from four historic GP practices. The newly formed practice started to provide regulated services from 13 October 2014. As a result, there is no historical QOF data for this practice. We reviewed QOF data published in October 2015 after our inspection. This showed that the practice had achieved 94.6% of the total number of points available compared to the CCG average of 98.2% and national average of 95.7%.

The practice had achieved the maximum points (100%) for conditions such as asthma, cancer, osteoporosis, depression, epilepsy and arthritis; and this was comparable to the CCG and national averages. This also included the rate of exception reporting with the exception of :

- osteoporosis which was 19% above CCG average and 18.6% above national average.
- depression which was 11.3% above CCG average and 11.2% above national average

Some examples of where lower values were achieved included the following;

- Performance for diabetes related indicators was 86% which was below the CCG average of 95.2% and the national average of 89.2%
- Performance for mental health related indicators was 84.6% compared to the CCG average of 98.1% and national average of 92.8%
- Performance for peripheral arterial disease related indicators was 83.3% compared to the CCG average of 98.6% and national average of 96.7%

The GP lead for QOF monitoring and other clinicians were aware of all the areas where performance was not in line with national or CCG figures. We saw action plans setting out how these were being addressed. This included strengthening the recall and read code recording system; and dedicated staff performing these duties were supported by the management.

A strong feature of the practice was the proactive use of clinical audits as tools for clinical development and improvement.

Good

Are services effective?

(for example, treatment is effective)

- We were shown eleven clinical audits completed since the practice opened on 13 October 2014. These covered medicines and specific long term conditions. For example, the audits on controlled drugs and antibiotic prescribing had clear outcomes of which staff had implemented to improve patient care.
- Although most of these audits were not completed cycles, schedules were in place to complete the second cycle within a one year period.

The systems in place for monitoring high risk medicines and those requiring regular blood checks were a strong feature of the practice. The practice maintained a register of 123 patients who were prescribed one or more of eight specific high risk drugs such as lithium and methotrexate.

A robust system was in place to recall patients for monitoring at specified intervals in line with recommended guidance. A total of 122 patients had received a medicine review and one patient had a future appointment scheduled for the review. This ensured that all patients received regular reviews of their medicines.

Prescribing data showed the practice was at the lower end of prescribing most drugs when compared with other local practices. This was achieved through collaborative working with the prescribing advisor and a CCG pharmacist. The practice had also signed up to the CCG led PINCER (a pharmacist-led information technology intervention for medication errors) initiative which enabled the GPs to identify patients at risk of prescribing errors. For example polypharmacy in older people and appropriate drug use in asthma. We saw examples to demonstrate medication errors were being reduced and the intervention promoted economic prescribing.

The practice participated in local benchmarking, peer review and research. For example, the benchmarking data for October 2014 to May 2015 showed the practice performed in line with the CCG average for the following areas: outpatient first attendances (all sources of referral), elective admissions (including day case) and emergency admissions, accident and emergency (A&E) attendances. All GPs were encouraged to audit their referrals as part of their peer review and appraisal.

The practice used the electronic palliative care co-ordination systems (EPaCCS) to record and share the preferences and key information about patients receiving end of life care. Staff told us this ensured proactive planning, anticipation of need and carer support. The practice had 41 patients on the palliative register and 75% had their information recorded on EPaCCS. An audit showed 96% of these patients had their diagnosis recorded, 92% had a preferred place of death recorded and improvement areas related to recording of carers (36%) and resuscitation status (70%).

Effective staffing

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

- The practice had an induction programme for all newly appointed staff that covered topics such as safeguarding, customer care, infection prevention and control, fire safety, health and safety and confidentiality. One clinical staff member we spoke with told us they had a good induction which covered the scope of their work.
- The practice ensured staff received role-specific and up to date training. For example, nurses reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- The learning needs of staff were identified through a system of supervision, meetings and review of practice development needs. Staff had protected learning time which enabled them to access e-learning training modules, CCG and in-house training to meet their learning needs. This included clinical supervision and support for the revalidation of doctors and nurses.
- We noted a good skill mix among the doctors with GPs having special interests and enhanced knowledge in areas such as child health/paediatrics, mental health/ psychiatry, elderly medicine, neurology and sexual health.
- Some doctors had external clinical roles, for example school doctor, sports club doctor, low secure unit primary care and provision of primary care to Nottingham's violent patients. This enabled sharing of clinical expertise within the practice

Coordinating patient care and information sharing

Staff worked together with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services or after they were discharged from hospital.

Good

Are services effective?

(for example, treatment is effective)

However, feedback from external health professionals we spoke with showed improvements were required to ensure effective multi-disciplinary working, sharing of relevant patient information in a timely way and the regular review of patient care. For example, the district nursing service raised some concerns about the lack of effective communication, limited attendance at multi-disciplinary meetings by clinical staff, inappropriate referrals or referrals not always being acted upon. These were shared with the leadership during the inspection and following our inspection a GP lead was assigned to address the concerns with the district nursing service.

The community matron spoke positively about engagement with the practice and cited improvements made in coordinating patient care since the practice opened.

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way on most occasions through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records, and investigation and test results.

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 and Gillick competency test. These are used to help assess whether a child under the age of 16 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 such as minor surgery and this was audited.

Health promotion and prevention

Another strong feature of the practice was the strategic work related to health and well-being. For example,

- One of the GP executive partners was the CCG lead for the health and wellbeing board and a member of the obesity steering group. They had contributed to the design of referral forms for patients to receive support with weight management; and these were used by GP's within the CCG area. The practice was instrumental in the establishment of this service which is commissioned by Public Health. The practice had referred 120 patients to date and 368 patients were receiving the weight management services within Nottinghamshire.
- The patient participation group (PPG) also promoted short walks on most Tuesdays leaving the surgery waiting area at 10.30am and again at 11.30am. This was aimed at promoting activity for people who may not otherwise go out for a walk alone and to create friendship opportunities. 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.
- People experiencing poor mental health were offered computerised cognitive behavioural therapy if appropriate and / or a prescription for recommended self-help books to help treat common issues such as stress, anxiety and depression.

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- 2014/15 data showed the practice had achieved 100% for smoking related performance indicators which was above the CCG average of 95.6% and national average of 95.1%. Records showed 1031 patients had been offered support with smoking cessation and 77 patients (7.46%) had stopped smoking.

Patients had access to appropriate health assessments and checks. These included:

- Health checks for new patients and NHS health checks for people aged 40–74. The practice had offered 246 NHS health checks and 163 (66%) patients took up this offer.
- The practice's uptake for the cervical screening programme was 84.6%, which was comparable to the CCG average of 88% and the national average of 81.8%. A nurse led audit showed 97.63% of cervical smears recorded between 13 October 2014 and 30 April 2015 were adequately taken.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Good

Are services effective?

(for example, treatment is effective)

- Childhood immunisation rates for the vaccinations given were comparable to the CCG and national averages. Childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.3% to 96.7% and five year olds was 96.1% as at 03 September 2015.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Eighteen patients completed CQC comment cards to tell us what they thought about the practice. All of the 18 patients felt the practice offered a good service and most staff were extremely helpful, empathetic and treated them with dignity and respect. Specific examples were given of staff being compassionate towards older people and young children. Two less positive comments were made in respect of the waiting times to be seen by the GP and the longer travel distance to the practice's new premises.

This feedback was aligned with the verbal feedback we received on the day of the inspection. We spoke with 13 patients including four members of 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.

Most of the patients told us they were satisfied with the care provided by the practice and that staff were thoughtful and caring. Less positive comments related to not always being able to see a preferred GP, the appointment system and waiting times.

Results from the national GP patient survey published in July 2015 showed patients felt they were treated with compassion, dignity and respect. The practice was in line with the clinical commissioning group (CCG) and national averages for most of its satisfaction scores on consultations with doctors and nurses. For example:

- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 90% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 89% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 99% said they had confidence and trust in the last nurse they compared to the CCG average of 98% and national average of 97%.
- 91% said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.
- 84% said the nurse was good at listening to them compared to the CCG average of 93% and national average of 91%.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room near the reception area to discuss their needs. We observed that members of staff were courteous and helpful to patients and treated people dignity and respect.

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decisions about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

We saw examples of care plans in place for patients with long term conditions such as diabetes, dementia and those experiencing poor mental health.

Results from the national GP patient survey showed that most patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mostly in line with CCG and national averages. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 82% 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 81%.
- 84% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- 76% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Most patients highlighted that staff responded compassionately when they needed help and provided support when required. This included maintaining regular contact with partners of patients with terminal illness and liaison with the Macmillan nursing staff.

The national patient survey results showed most patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 85% said they found the receptionists at the practice helpful compared to the CCG average of 91% and national average of national average 87%.

The practice had identified 246 (about 1.4%) patients as carers and they were offered health checks, flu vaccinations and referrals for social care assessments as appropriate. Identification of young carers was in progress. Written information including a carer's information pack was displayed in the waiting area to direct carers to the various avenues of support available to them. This included support groups, short breaks and extra care.

Rushcliffe CCG has commissioned a carers service in partnership with Carers Federation to ensure carers are informed of their rights and receive appropriate support with their caring roles. We spoke with the adult carers support worker who visited the practice fortnightly on a Friday afternoon. They told us staff were proactive in referring patients to the service and they had good engagement with them to ensure positive outcomes for the carers. One of the GP partners had also been involved in interviewing the clinical leads for the carers' service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

It was evident from our staff interviews that the whole team worked well together and strived to provide a responsive and patient focused service. Staff were very open about their achievements including the challenges they had overcome following the merger of the four local practices to form Castle Healthcare practice. This included improving telephone access and waiting time; integrating IT systems as well as patient engagement and education.

The practice reviewed the needs of its local population and engaged with Rushcliffe clinical commissioning group (CCG) and NHS England to secure improvements to services where these were identified. These included the CCG's three priorities: to support people manage on-going conditions; improve their mental health and wellbeing; and to promote prevention, early intervention and supporting people to make healthy lifestyle choices.

For example, the practice provided enhanced support to three local care homes to improve the quality of care for older people by reducing unplanned admissions, ambulance transfers, length of inpatient stays and falls. Data reviewed showed reduced nursing home emergency appointments for the CCG as a result of this service provision. The enhanced support also included:

- weekly care home visits by the lead GPs for each home to ensure continuity of care.
- joint visits with the pharmacist to review patients' medicines.
- engagement and joint care planning arrangements with other stakeholders such as the community geriatrician, the falls team, adult social care and specialist nurses including the tissue viability nurses.

One of the GP partners was the CCG lead for frail elderly persons and had been actively involved in the development of an integrated GP hospital in reach team to help with earlier discharge of patients.

The practice also provided an enhanced service for the monitoring and management of long term conditions including shared care drug monitoring; to reduce avoidable hospital admissions and improve the quality of life for patients. Patients had access to GPs and nurse led clinics from 8am to 8pm. This included diabetes and asthma clinics and phlebotomy services.

The practice worked with young people to promote healthy lifestyle choices. This included sexual health and reducing obesity amongst adolescents. The practice is close to two secondary schools and staff had engaged with sixth formers in one of the schools.

The practice was signed up to the c-card scheme which allowed young persons to get access to information on relationships, contraception and sexual advice. One of the GP partners had a special interest in teenage health and worked as a school Doctor and another GP had initiated the Public Health adolescent strategy within the local area.

The practice offered a wide range of services to patients and this included family planning (including contraceptive implants and coils), in-house ultrasound clinics, antenatal clinics, minor surgery, joint injections and a travel clinic. The practice also hosted other services including a physiotherapy service and an on-site pharmacy with extended hours licence.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example:

- Reasonable adjustments had been made to ensure accessible premises for people with a range of impairments. For example, some patients with learning disabilities and visual impairment were given a tour when the building was opened and longer appointments were offered if needed.
- There were facilities for people with disabilities including a hearing loop system.
- Other facilities included a breastfeeding room, pram park and translation services for patients who did not have English as a first language.
- Patients could access the practice via a lift from the car park. However some patients told us the lift was not always functional and therefore they had to use the ramp.
- The practice funded a free bus service between 8am and 4.30pm in conjunction with Sainsbury's. We received three comments from patients highlighting the new location of the practice had increased their travel time and they could not always access this bus service.

Access to the service

The practice was open between 8am and 8pm Monday to Friday with appointments available within these times. A same day triage service was offered from 8am to 6.30pm

Good

Are services responsive to people's needs?

(for example, to feedback?)

alongside a pre-bookable appointment system. Patients could access same day urgent appointments, telephone consultations and pre-bookable appointments up to four weeks in advance

Patients with urgent health care needs could also access appointments on Saturday and Sunday between 8.30am and 12.30pm from a local practice.The practice staff participated in the weekend service which was funded by the Prime Minister's GP access fund.

Patient feedback about access to the service was mixed. For example, comments received from Healthwatch and on the NHS Choices website showed most patients were not happy with the telephone access, availability of urgent and non-urgent appointments and the waiting times to be seen or to be called back by the duty doctor. They felt the merger of the four practices had resulted in accessing services being a challenge compared to their previous experiences prior to the merger.

This was aligned with the national patient survey published in July 2015. Satisfaction scores relating to phone access and waiting times were lower than the local and national averages.

- 61% of patients said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.
- 56% of patients said they usually waited 15 minutes or more after their appointment time compared to the CCG average of 36% and national average of 35%.
- 60% felt they normally waited too long to be seen compared to the CCG average of 55% and national average of 58%.

We also noted the rate of accident and emergency attendance was slightly above Rushcliffe average. However, the practice was aware of this less positive feedback and had engaged with the patient participation group (PPG) to drive improvements. 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, they had changed the appointment system to include a triage system and online appointments could be booked a month in advance.

The practice had effective systems in place to audit patients' access to the service. This included a visual electronic board to record the number of calls received, responded to and how long patients had been waiting for. This information was then used to assess patient demand and services required. Records reviewed showed reduced waiting times as better access was being offered to patients.

Most of the patients we spoke with were satisfied with the appointment system and said it had improved within the 11 months of the practice providing services. They confirmed routine appointments were usually available within two to three weeks and they could see a doctor on the same day if their need was assessed as urgent; although this might not be their GP of choice.

This was aligned to the national GP patient survey results. For example:

- 95% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 90% and national average of 85%.
- 83% usually get to see or speak to their preferred GP compared to the CCG average of 61% and national average of 60%.
- 74% described their experience of making an appointment as good compared to the CCG average of 80% and national average of 73%.

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; for example information on the notice boards and internet.

We looked in detail at 12 out of 44 complaints received in the last 11 months. We found these were satisfactorily handled, dealt with in a timely way showing openness and transparency in response.

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, improvements to telephone access and the appointment system. In addition, a patient's do not attempt resuscitation (DNAR) form had a misspelling on it which rendered it invalid. As a result of this, all DNAR forms

Good

Are services responsive to people's needs?

(for example, to feedback?)

are now mail merged instead of being handwritten to ensure the accuracy of the form. Key themes from complaints were also reviewed to inform service improvement.

Are services well-led?

Good

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

Our findings

Vision and strategy

Castle Healthcare Practice was opened on 13 October 2014 and is a merger of Ludlow Hill Surgery, Trent Bridge Medical Practice, Compton Acres Medical Centre and Southview Surgery.

Our overall inspection findings showed most systems had been effectively organised to ensure a smooth transition of the four practices into a cohesive and seamless organisation. This had been achieved by the implementation of effective work streams and robust business planning arrangements that had been initiated in 2008. Prompt action was taken to address system problems and other challenges such as staff integration when improvement was needed.

Staff felt the merger of the practice was in itself a fulfilment of an inspiring vision and were very proud of the achievements made within the 11 months. There was strong evidence throughout the practice that team spirit and motivation was high.

The practice had a very clear vision to prioritise and deliver safe, high quality and compassionate care. The strategies to achieve this vision were stretching, challenging and innovative whilst remaining achievable. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

The practice sought out new models of care as informed by the NHS five year forward view and were looking to deliver community based services in the future. The Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients and carers so as to promote wellbeing and prevent ill-health.

Governance arrangements

The practice had refined the governance arrangements inherited from the four practices and developed an overarching governance framework which supported the delivery of good quality care. This was supported by:

- A clear staffing structure in place with staff being aware of their own roles and responsibilities.
- Practice specific policies and guidance being implemented by staff.
- A comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions
- A systematic approach to improving and monitoring patient outcomes; including engagement with patients, carers, staff and key stakeholders.

Leadership, openness and transparency

The practice management team were keen to develop and model excellent teamwork. They had employed a team-development model that was based on forming, storming, norming and performing stages. This model explains that as the team develops maturity and ability, relationships establish, and the leader changes leadership style. The partners were visible in the practice and staff told us that they were approachable and took the time to listen to them.

The leadership had the experience, capacity and capability to run the practice and ensure high quality care. For example:

- Executive meetings were held every Thursday morning and included the business manager and the GP partners responsible for management, finance and human resources. The GPs felt this provided a robust framework for strategic communication and decision making.
- All partners met quarterly on a Saturday morning to reflect on and evaluate on the practice's vision.
- Full-time GPs had four hours per month protected time to enable them to undertake their leadership role.
- The individual staffing groups held regular team meetings and staff told us that there was an open culture within the practice. They had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.

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

The practice encouraged and valued feedback from patients', the public and staff.

Are services well-led?

Good

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

The practice had gathered feedback from patients through the patient participation group (PPG), family and friends test, surveys and complaints received. There was an active PPG which included eight cabinet members and 20 forum members. 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. They met on a regular basis alongside a virtual group and produced meeting minutes and a regular newsletter for other patients to review.

We spoke with four PPG members and they all felt patient involvement was seen as integral to how the practice reviewed and improved services. They also gave examples of how management had been responsive to proposals for improvements. The leadership described the PPG as being: integral in creating the recently merged practice; supportive and this has enabled the practice to enhance patient care.

The practice gathered feedback from staff through meetings, discussions and social events.Staff we spoke with said they felt respected, valued and supported. Social events were actively promoted to encourage interaction and celebrate good performance.

The GP lead for human resources told us promoting staff health and wellbeing was recognised as a contributory factor to the overall wellbeing and performance of the practice. As a result all staff were encouraged to be involved in decision making, problem solving and innovation at all levels. This also included devolved leadership amongst the GPs and non-clinical staff. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. For example:

- Three new staff nurses were being supported to undertake the practice nurse degree programme at a local university and the nurse manager was in process of setting up meetings on revalidation.
- The practice was research accredited by the Royal College of General Practitioners and a training practice for GP registrars.

The practice team was forward thinking and actively involved in developing and / or implementing local pilot schemes to improve outcomes for patients in the area. Specifically, care for people experiencing poor mental health, older people living in care homes, elderly and frail, adolescents and patients requiring integrated health and social care. A variety of initiatives were also being considered and these included facilitating Wi-Fi in care homes and piloting use of IT system in care homes.

Some of the GP partners held external roles in which strategic decisions for the local area were made to improve patients care. For example:

- One GP partner was the clinical lead for the Rushcliffe Integrated Care Services (RICS) and was leading on developing comprehensive integrated health and social teams, and multi professional agency for continuing healthcare for example. They also sponsored all the public health obesity work at the local health and wellbeing board.
- Another GP partner was the CCG lead for mental health and chair of Rushcliffe Mental Health group. They were involved in the strategic review of local mental health services, liaison between primary and secondary care and leading on new innovative services. For example, project working the Rushcliffe Vanguard model to move liaison psychiatry into primary care to examine if this will improve management and decrease admission rate for patients with particularly severe medically unexplained symptoms.