# The Ruddington Medical Centre

## 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 the Ruddington Medical Centre on 09 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for all the population groups we inspected.

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

- Risks to patients were mostly assessed and well managed. However, recording systems in respect of the management of the practice and staff employed needed strengthening to ensure a safe service. This included infection control policies, procedures for dealing with emergencies and staff records.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Most patients said they found it easy to make an appointment and urgent appointments were usually available the same day. Some patients felt improvements were required in respect of the availability of non-urgent appointments, in particular if they wished to see a specific GP or outside working hours.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management.
- The practice 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 (PPG).

# Summary of findings

- There were high levels of engagement between the practice and patient participation group (PPG) to encourage: patients to be more proactive in managing their conditions; provide information and support for carers; and ensure the regular review of services.

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

The provider should:

- Improve the availability of non-urgent appointments and flexibility of access to appointments for the working age population group.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all staff have appropriate policies and guidance to carry out their roles in a safe manner.
- Ensure systems for assessing, monitoring and recording risks and the quality of the service provision are strengthened.
- Ensure an up to date business plan is in place and discussed with all staff.

**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.

Most of the risks to patients and staff were assessed. The recording and processes to address these risks needed strengthening to ensure people were kept safe. This included infection control, health and safety, recruitment and management of unforeseen circumstances / emergencies.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement.

We found appropriate systems were in place to ensure patients were safeguarded from abuse, equipment was safely maintained and the management of medicines. There were enough staff to keep patients safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely in their assessments.

Data reviewed showed most patient outcomes were in line or above average when compared to neighbouring practices in the Clinical Commissioning Group. Clinical audits were carried out to monitor and improve the care and outcomes for patients.

Staff worked with other health and social care professionals to improve patient outcomes. Regular multi-disciplinary meetings were held and the practice had identified the need to improve the recording of discussions and agreed actions.

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

Effective systems were in place in respect of information sharing with other services and promoting health promotion and prevention.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

# Summary of findings

Patients told us they were treated with compassion, dignity and respect. They described staff as being friendly, caring and helpful. This was reflected in the data we looked at which showed positive patient feedback in relation to involvement in decisions about their care and treatment.

The practice had good systems in place to support carers and patients to cope emotionally with their health and condition. Information to help patients understand the services available was easy to understand.

We saw that staff were respectful and polite when dealing with patients, and maintained confidentiality. They were able to give positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders such as care home managers were positive and aligned with our findings.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

Most patients were generally satisfied with the appointment system and confirmed being able to see a doctor and / or nurse when needed. Some patients reported access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.

Improving phone access and the appointment system was a priority area for the practice. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG).

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. The practice worked in liaison with other health social care professionals to ensure patients' received care and treatment when needed.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised. Learning from complaints was shared with staff and other stakeholders to improve the service.

**Are services well-led?**

Good

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

# Summary of findings

The practice had a vision in place and staff were committed to improving the quality of care and services for patients. The strategy to deliver this vision was being reviewed in response to staff changes and patient feedback. There was a clear leadership structure and staff felt supported and valued by management.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. Staff received inductions, performance reviews and attended staff meetings and events. These governance arrangements needed strengthening to ensure the practice continued to provide high standards of service.

The patient participation group (PPG) was very active and there was a high level of constructive engagement with the practice staff to improve patient outcomes and the delivery of service. This was an outstanding feature for the practice.

# 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.

Patients aged 75 years and over were allocated a named GP to provide continuity of care. The practice offered personalised care to meet the needs of older people including a range of enhanced services, for example in dementia and end of life care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

The GPs worked closely with the community matron and geriatrician to assess older people's care needs and plan the delivery of their care. Annual health checks including flu vaccinations were offered and referrals were made to services such as the falls team to reduce the risk of falls.

The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Weekly nursing home visits were undertaken, and this was acknowledged positively in feedback received from two care home managers. Carers were identified and supported to care for older people.

**People with long term conditions**

Good

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

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Appropriate care plans were put in place to support patients' care needs and enable them to remain at home, where possible.

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

Longer appointments and home visits were available when needed. Nationally reported data showed that outcomes for patients with long term conditions were good. Emergency processes were in place and referrals were made for patients who had a sudden deterioration in health.

**Families, children and young people**

Good

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

# Summary of findings

The practice prioritised appointment requests for children and young people. Patients we spoke with and comment cards received confirmed same day appointments for children were provided. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice offered immunisation services for children and young people as well as family planning services. Immunisation rates were relatively high for all standard childhood immunisations.

We saw good examples of joint working with health visitors and midwives. This included monthly multi-disciplinary meetings to discuss concerns relating to specific families and / or children; and ways to support them and ensure their safety.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of abuse. Staff had received relevant training on safeguarding vulnerable children and adults; and knew how to respond to signs of abuse.

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.

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

Good

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

The practice had adjusted most of the services it offered to ensure they were accessible and flexible to meet the needs of this population group. Patients could access telephone consultations and online services for ordering repeat prescriptions and booking appointments. Patient feedback showed most people were happy with the appointment system and some patients felt the availability of non-urgent appointments needed to be reviewed.

The practice was not signed up to extended opening hours; however were actively reviewing access arrangements for working age people. Staff were involved in a pilot to provide GP access at the weekend within the local area.

A choose and book service was available for patients referred to hospitals or other secondary health services. This service enabled patients to book their own appointments and provided greater flexibility over when and where their medical examination took place.

The practice was proactive in offering health promotion and screening services that reflected the needs for this age group. This

# Summary of findings

included NHS health checks being offered to patients aged 40 to 74 years and promoting of self-management of health conditions. Students were able to register as temporary patients during the school holidays.

**People whose circumstances may make them vulnerable**

Good

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

The practice held a register of patients living in vulnerable circumstances including people with a learning disability, epilepsy and in need of palliative care. The practice provided care to 70 registered patients with a learning disability, behavioural and mental health issues. Most of these patients resided in three local care provisions registered with the Care Quality Commission. Two senior staff members told us a good and responsive service was offered for their patients.

The practice had carried out annual health checks for people with a learning disability. They told us continuity of care was maintained by the GPs and their health books were completed. Health promotion services such as flu vaccinations, administration of insulin and weight clinics were offered by the practice.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. This included the community learning disability team, community matron and the Macmillan nurse for patients receiving end of life care. Longer appointments and home visits were provided where needed.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Information was available to patients about how to access various support groups and voluntary organisations in a format they could understand.

**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 worked with other multi-disciplinary teams to ensure the care needs of people experiencing poor mental health and dementia were regularly reviewed. This included working with care home staff in respect of advance care planning for people with dementia and referral to a local memory clinic for patients identified at risk of dementia. The majority of patients on the dementia register (88%) had received an annual review of the care needs.

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The GPs worked closely with psychiatric consultants to ensure coordinated care for patients with both physical and mental health needs. This included facilitating risk assessments and care plans where appropriate, and regular review of their medicines. The practice had 37 patients on mental health register and 91% had received an annual physical health check.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Patients experiencing poor mental health had access to information on various support groups and voluntary organisations including counselling services / talking therapy.

# Summary of findings

## What people who use the service say

We spoke with six patients during the inspection and received 97 comment cards from patients. 65 cards contained positive feedback about the care the patients had received and 31 cards contained mixed feedback. The common themes of the less positive areas were in relation to phone access, appointments and waiting times.

Overall, most patients expressed a high level of satisfaction about the care and services provided and felt sufficiently involved in decisions about their care and treatment. Patients told us they could access urgent appointments or speak to a GP or a nurse when they needed to. Most patients described the staff as friendly, caring and helpful, and felt that they were treated with dignity and respect. Patients described the premises as safe and hygienic, and felt the facilities were accessible.

We looked at the January 2015 national GP survey results of which 118 patients had completed. Overall, 81% of patients described their overall experience of the practice as good. The practice achieved high scores in respect of involving patients in decisions about their care and lower scores in respect of continuity of care, phone access and the appointment system. The practice showed us evidence to demonstrate these areas where being reviewed in liaison with the PPG.

The practice had an active Patient Participation Group (PPG). The PPG is a group of patients who work with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We spoke with the chair of the PPG. They told us that they worked in partnership with the practice to improve the service and had their full support to ensure that patients' views were listened to and acted on.

The PPG were involved in promoting the completion of comment cards for the family and friends test and as a result 247 cards had been completed between 08 December 2014 and 31 January 2015. The results showed that 91% of patients said they were likely or extremely likely to recommend the practice patients completed.

We also spoke with senior staff at four care homes where the residents were registered with the practice. This included older people and people with learning disabilities. The care home staff praised the care and service patients received and the support offered to meet patient's needs. They said that patients were promptly seen and their needs were regularly reviewed; and any concerns were dealt with appropriately.

## Areas for improvement

**Action the service SHOULD take to improve**

- Improve the availability of non-urgent appointments and flexibility of access to appointments for the working age population group.
- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all staff have appropriate policies and guidance to carry out their roles in a safe manner.
- Ensure systems for assessing, monitoring and recording risks and the quality of the service provision are strengthened.
- Ensure an up to date business plan is in place and discussed with all staff.

# The Ruddington Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC inspector and included a GP, a practice manager and a second CQC Inspector.

## Background to The Ruddington Medical Centre

The Ruddington Medical Centre is a partnership between two GPs providing primary medical services to approximately 6,700 patients living within the following practice areas: Ruddington, Bunny, Edwalton, Silverdale, Wilford, Compton Acres and some parts of West Bridgford. The practice also provides care to a total of six local care homes for older people and people with learning disabilities.

The practice has two GP partners, one male and one female. The clinical team includes two GPs, a specialist nurse practitioner, two practice nurses and a healthcare assistant. They are supported by a practice manager, a support services manager and nine administrative staff.

The practice is a training practice for GP registrars and F2 trainee doctors (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine).

The practice holds a General Medical Services (GMS) contract with the NHS to deliver essential primary care services. These include minor surgery, family planning and baby clinics, travel vaccinations and health promotion and a range of services for patients with long term conditions.

The practice has opted out of providing the out-of-hours services to their own patients. Information was available on the website and on the practice answer phone advising patients of how to contact out of hours service outside of practice opening hours.

## 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 practice had not previously been inspected and that was why we included them.

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

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

# Detailed findings

## How we carried out this inspection

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

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

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

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

Prior to our inspection we reviewed information about the practice and asked other organisations to share what they knew about the service. This included: NHS England, Rushcliffe Clinical Commissioning Group (CCG), and four providers of health and social care services who worked closely with the practice.

We carried out an announced visit on 09 February 2015. During our visit we observed how people were being cared for and spoke with the six patients, including the chairman of the Patient Participation Group (PPG). We also spoke with a range of practice staff including GPs, the nurse practitioner, a practice nurse, a healthcare assistant, the practice manager, support services manager and reception staff. We also received 97 comment cards we had left for patients to complete.

Good

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents, accidents and comments received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an accident book was maintained within the practice and incidents such as needle stick injuries were recorded.

We found staff recorded the incidents in a timely manner and dealt with these injuries appropriately. This included acting upon advice given by occupational health to ensure the safety of staff and patients. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We also saw minutes of meetings where safety incidents were discussed within the last 12 months. This showed the practice monitored and reviewed risks related to safety incidents over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed records of seven significant events that had occurred during the last year. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, a robust system was put in place to ensure that patient information was recorded on the practice electronic system following an incident where a letter with key information had not been added to a patient's record.

Patients were also given an apology and informed of the actions taken where they had been affected by something that had gone wrong.

There was a system in place to ensure that staff were aware of national patient safety alerts and where action needed to be taken. Clinical staff told us alerts were discussed as a group to ensure all staff were aware of any alerts that were relevant to the practice. Staff were able to give examples of recent alerts that were relevant to the care they were responsible for. Records showed that safety incidents and concerns were appropriately dealt with.

### Reliable safety systems and processes including safeguarding

The practice had good systems and processes in place to keep patients safe and safeguarded from abuse. This included a safeguarding policy which provided guidance for staff to take when suspected abuse and / or concerns were identified.

Staff we spoke with knew how to recognise signs of abuse in children, young people and vulnerable adults. They were also aware of their responsibilities to share information with relevant agencies such as the multi-agency safeguarding hub and maintain appropriate documentation of safeguarding concerns. Contact details of the local safeguarding teams were easily accessible to staff on notice boards.

Training records reviewed showed all staff had received relevant role specific training on safeguarding. For example, all administration staff had received level one training for safeguarding children and vulnerable adults in January 2015. The practice had a GP lead for safeguarding vulnerable adults and children; and they had completed level three training to enable them to fulfil this role. Most of the staff we spoke with were aware of who the GP lead was and whom to speak with if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. For example, GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. This ensured that staff were aware of any relevant issues when patients attended appointments. The lead safeguarding GP was aware of vulnerable children and adults, and records demonstrated good liaison with partner agencies such as social services.

Meeting minutes reviewed showed monthly multi-disciplinary meetings were held with the GPs, practice nurse, health visitor, school nurse and midwife. They discussed concerns relating to specific families, children, young people and vulnerable adults.

This included: follow up of children who did not attend appointments for childhood immunisations or where there were concerns relating to their development; and those living in disadvantaged circumstances. The practice was

also looking to develop a template which would enable discussions and agreed actions to be recorded contemporaneously onto the patient record during the meetings.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

All nursing staff including the health care assistant had been trained to be a chaperone. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Reception staff did not undertake chaperone duties.

### Medicines management

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

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

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

A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role. This included updates in the specific clinical areas of expertise for which they prescribed.

There was a system in place for the management of high risk medicines and repeat medications which included regular monitoring in line with national guidance. For example, we saw that the Clinical Commissioning Group (CCG) pharmacist had undertaken an audit of controlled drugs.

The audit reviewed opioid prescribing by the clinicians (except tramadol) and ensured that patients who had received high dose prescribing were highlighted to the senior GP. Opioids are medicines prescribed for the relief of moderate to severe pain. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines.

Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. The pharmacist had also reviewed the reasons for GPs prescribing red drugs and provided feedback as part of improving their medicines management. Red drugs are prescribed drugs which should be under specialist care.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Patients told us that the system in place for obtaining repeat prescriptions generally worked well to enable them to obtain further supplies of medicines.

The practice also reviewed its prescribing data in respect of patterns of antibiotic, hypnotics and sedatives to ensure appropriate action was taken to address any areas of concern and / or promote good practice. We saw that any identified prescribing error was reviewed as a significant event to promote shared learning and that appropriate action was taken to ensure the patient received safe care.

### 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. We saw there were cleaning schedules in place and cleaning records were kept. However, the cleaning schedules had prepopulated ticks for advance dates and gave the impression that cleaning had been done for a future date. This was discussed with the infection control lead to ensure improved recording on cleaning schedules.

An infection control policy and supporting procedures were available for staff to refer to when planning and implementing measures to control infection. However,

Good

# Are services safe?

some of these policies had not been personalised to the practice's working arrangements to ensure they were relevant. For example, the practice relied on a local NHS trust policy last reviewed in 2010 as guidance in relation to the management of blood, body fluid and vaccine spillages. This needed review to ensure staff were referring to up to date guidance that was relevant to the practice.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. An infection control audit had been completed on 24 January 2015 and areas of improvement were being addressed. Records reviewed showed 11 out of 14 non-clinical staff had received training about infection control specific to their role and further training had been planned.

Although the practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal), we were shown records to evidence that a legionella risk assessment was due to be completed on 24 February 2015 by an external company. The staff also undertook weekly flushing of water taps as part of regular checks to reduce the risk of infection to staff and patients.

The practice management was aware of the guidance relating to the immunisation of staff at risk of the exposure to Hepatitis B infection through their work. We saw some clinical staff Hepatitis B vaccination records; however full records were not available for all relevant staff to show they were protected from Hepatitis B infection. Other areas requiring improvement included ensuring that sharps bins were signed and dated on assembly and locking and use of purple lidded bins for sharps storing contaminated cytoxic and cytostatic medicines. Staff told us this would be addressed after our inspection.

We saw that personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

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

### Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place and any equipment that had failed the testing was replaced.

We saw evidence of calibration of relevant equipment spirometers, blood pressure measuring devices and the fridge thermometer. They had been calibrated on 11 February 2014 and further testing had been scheduled for 15 April 2015.

### Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed the records of five staff members employed after the practice was registered with the Care Quality Commission on 20 December 2012. We found three out of five staff files contained records to demonstrate that appropriate recruitment checks required by law had been undertaken prior to their employment. The files included staff's proof of identity, qualifications, pre-employment histories, references and registration with the appropriate professional body.

However, we found the provider had not applied for up to date Disclosure and Barring Service (DBS) checks in regards to two clinicians and a practice manager who had started work in 2014. The provider had accepted DBS checks undertaken by other employers which are no longer portable unless registered with the DBS service. This was discussed with the management as requiring urgent action.

After our inspection, we were provided with records to demonstrate that the application process for DBS checks had been initiated and we will follow-up to ensure it is completed. We noted that other staff had appropriate DBS checks in place and these were risk assessed every three years.

The practice manager told us that new staff were required to complete a health disclaimer, and we saw evidence in

Good

# Are services safe?

three of the five staff files. Following our inspection we were told that satisfactory information about any physical or mental health conditions, which are relevant to the person's ability to carry out their work had been obtained.

Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff 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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

## Monitoring safety and responding to risk

The practice had a health and safety policy, which staff had access to. There was also a health and safety representative but not all staff were aware who they were. There was a health and safety poster displayed for staff reference. The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. However these needed strengthening to ensure they were robust.

There was evidence that various risk assessments had recently been completed in regards to the environment, display screen equipment, control of substances hazardous to health and the facilities. However, the resulting action plans were yet to be completed and the management had identified this as a high priority for completion.

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

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records reviewed showed most staff had received training in basic life support. Additional training for staff had been arranged for March 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

An appropriate business continuity plan was not in place to deal with a range of emergencies that may impact on the daily operation of the practice. The existing business plan had last been reviewed in March 2012 and cover arrangements detailed were out of date. The practice manager told us it was high priority for the management to provide an updated business plan, together with relevant contact details for staff to refer to; and this would be addressed after our inspection.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff regularly tested the fire alarm system to ensure it was working. Training records reviewed showed most staff members had up to date fire safety training, two required refresher training in February 2014 and four staff had not completed this training.

Records showed that staff had carried out a fire drill on 4 February 2015 to ensure they knew what to do in the event of a fire. However, these were not carried out at regular intervals as the previous fire drill was last carried out in August 2012.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Feedback from patients and health care professionals showed the practice delivered effective care and treatment on most occasions. We found the practice management were aware of the health and social care needs of the practice population and had a holistic approach to assessing and meeting patients' needs. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Staff told us new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. This was designed to ensure that each patient received support to achieve the best health outcome for them. We saw limited evidence of this in the minutes of meetings we looked at and the practice acknowledged this as an area of improvement.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice had effective systems in place for clinical peer review and support. GP review meetings were held at least twice a month to discuss patients with complex needs, home visits, referrals and discharges from hospital.

Staff told us they respected each other's specialist clinical areas and maximised on their different skills and experiences. For example, the assessment and review of long term conditions such as diabetes and asthma was jointly undertaken by the GPs and practice nurses. The practice staff also liaised with the specialist diabetic nurse in respect of insulin initiation and continual monitoring of diabetic patients. This ensured the effective management of patient's diabetes.

National data showed that the practice was in line with referral rates to secondary and other community care services for most conditions. Staff told us regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. For example, GPs we spoke with used national standards for the referral of patients with suspected cancers to ensure they were seen within two weeks.

We saw that the practice had also undertaken an audit of all the two week wait referrals made between April and September 2014.The findings showed eight patients were confirmed with a diagnosis of cancer out of the 33 referrals made. 16 patients required further investigations to rule out cancer and the rest of the patients were discharged after their initial appointment. The GP audit concluded that appropriate referrals had been made.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews and ensuring that the practice adhered to initiatives such as specific enhanced services. The information staff collected was then used to support the practice to carry out clinical audits.

The practice showed us five clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. We saw a completed audit of irritable bowel syndrome (a long-term condition of the digestive system), which showed improvements had been made in the type of blood tests required prior to the diagnosis.

Another audit reviewed related to the diagnosis and coding of patients with dementia. One of the recommendations was to review current patients and ensure that blood tests were appropriate. The practice QOF data as at 06 February 2015 showed 91% of 70 patients on the dementia register had received a review and 73% of bloods had been done for patients newly diagnosed with dementia.

Good

# Are services effective?

## (for example, treatment is effective)

We were informed that an audit to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance had not been recently completed. The practice agreed to undertake this post our inspection.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The 2013/14 QOF data showed the practice had met all the minimum standards for diabetes, asthma and chronic obstructive pulmonary disease for example; and achieved a total score of 95.8%. This practice was not an outlier for any QOF or other national clinical targets.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the QOF data as at 06 February 2015 showed: 80% of patients on the asthma register had received a review in the last twelve months; 75% of patients on rheumatoid arthritis register had received an annual review and 100% of patients on the cancer register had received a review since diagnosis.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice also participated in local benchmarking run by the Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the December 2014 CCG report showed the practice was average or below average for the majority of specialities were the patient was discharged from hospital after their first outpatient attendance.

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

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

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

The practice were signed up to the electronic palliative care co-ordination system (EPaCCS) which enables the recording and sharing of people's care preferences and key details about their care at the end of life. The practice had identified the need for clinicians to improve the recording of end of life care decisions using templates within the patient electronic record system.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff told us that they received essential training to carry out their work. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as basic life support. A training matrix was used to monitor staff training and further training sessions had been arranged for most courses that staff had not attended and the provider considered essential.

The delivery of staff training included formal induction and shadowing experience, e-learning and attending protected learning events. Staff that had been in post for over a year received an annual appraisal that identified their learning needs from which action plans were agreed and reviewed.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment

Good

# Are services effective?

## (for example, treatment is effective)

called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and wound dressings. Those with extended roles for example seeing patients with long-term conditions such as asthma, diabetes and chronic obstructive pulmonary disease (lung disease), were also able to demonstrate that they had appropriate training to fulfil these roles.

We saw evidence of a nurse team building event held on 30 September 2014, which discussed developments in respect of immunisations, B12 insulin, smear updates and anaphylaxis (sudden allergic reaction that can result in rapid collapse and death if not treated).

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically, by fax and or post.

Staff we spoke with were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. We however noted that only one member of staff was responsible for summarising patient notes. This potentially increased the risks of delays in processing the information in their absence.

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

Records reviewed showed regular multi-disciplinary meetings were held with other providers to discuss and review the needs of complex patients. These included older people living in care homes and people with long term conditions receiving support from a range of professionals. These meetings were attended by care home managers, the community matron and community teams, and decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information and addressing any concerns.

Staff gave examples where multi-disciplinary discussions had facilitated positive outcomes for patients. This included the delivery of coordinated care for people with mental health needs and learning disabilities in liaison with the local mental health team, learning disability community team and relevant consultants.

The practice staff maintained strong links with a range of community specialist nurses to support patients better manage their long term conditions. This included nurses specialising in chronic obstructive pulmonary disease and congestive cardiac failure (heart failure) as well as a geriatrician, who specialises in the medical care for the elderly.

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice received out of hour's information via fax. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Electronic systems were in place for making referrals via the Choose and Book system. This is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

Good

# Are services effective?

## (for example, treatment is effective)

Examples of referrals made were for diabetic retinopathy screening and for patients to attend a structured education programme for type two diabetes, which is not treated with insulin.

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

### Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Records reviewed showed most of the staff had attended relevant Mental Capacity training. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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

The practice's QOF data as at 06 February 2015 showed 91% of the 71 patients on the dementia register had received a review of their care needs. The practice had identified that one care home provider for people with learning disabilities were not bringing their residents for annual health reviews on invitation. This was considered as a significant event and an agreed action was for the reviews to be completed at the care home.

Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. One example included the involvement of an Independent Mental Capacity Advocate (IMCA) and the community matron in the decision making for end of life care arrangements for a patient. An IMCA's role includes safeguarding the rights of people who are facing a decision about a serious medical treatment and lack the capacity to make a specified decision at the time it needs to be made.

All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

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

### Health promotion and prevention

The practice ethos in respect of health promotion stated "we firmly believe that preventing illness is better than trying to control or cure it". We found the practice offered a variety of health promotion checks and the Patient Participation Group (PPG) actively provided support in promoting them.

For example, the PPG were involved in facilitating health awareness events such as the "self-care for life – be healthy this winter" campaign which was held between 17 to 23 November 2014. This yearly campaign raises awareness about the benefits of self-care and what you can do to take care of your own health at home. The practice was one out of four practices within the Rushcliffe CCG area that was an information point for patients.

The practice was proactive in offering flu vaccinations to people with learning disabilities, those with long term conditions and older people. The 2013/14 QOF data showed a high uptake of the flu vaccinations. For example, 95% of people on the diabetes and coronary registers were given the flu jab in the last season as well as 94% on the stroke register.

At the time of our inspection, 78.1% of patients aged 65 and over had received the flu vaccination. This included registered patients living in care homes. PPG members also helped out in greeting and ushering 826 patients that had attended the practice's flu vaccination clinics in 2014.

Good

# Are services effective?

## (for example, treatment is effective)

It was practice policy to offer a health check with the practice nurse / healthcare assistant to all new patients registering with the practice. New patients with pre-existing long term conditions were offered a review of their health needs and the GP was informed of all health concerns detected to ensure appropriate follow-up.

We noted a culture among the clinicians to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example by offering smoking cessation advice to smokers. The QOF data as at 06 February 2015 showed that 71% of current smokers aged 16 and over had been given relevant support and 80% had been given advice in relation to chronic disease management.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 146 patients took up the offer for this health check between 01 October 2014 and 09 February 2015. We were told that further investigations and follow-up were made if risk factors for specific diseases were identified at the health check.

The practice also offered NHS abdominal aortic aneurysm (AAA) screening to men aged 65 years and above. The AAA screening programme was introduced after research showed it should reduce the number of deaths from burst aneurysms among men aged 65 and over by up to 50%.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering annual physical checks and additional help. This included patients with a learning disability, mental health needs and older people aged 75 and over.

The practice's performance for cervical smear uptake was about 87%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. The practice maintained a sexual health register and a record of emergency contraception given.

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

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included: information from the January 2015 national patient survey results, patient satisfaction questionnaires completed as part of the NHS friends and family test, and the practice's most recent survey of which 300 patients completed. The evidence from all these sources showed most patients were satisfied with how they were treated and this was with compassion, dignity and respect.

For example, the practice was rated above the local Clinical Commissioning Group (CCG) average in the following areas: 99% of respondents said they had confidence and trust in the last nurse they saw or spoke to and 86% said that the last nurse they saw or spoke to was good at involving them in decisions about their care. Out of 118 respondents 87% also found the receptionists very helpful. We observed staff speaking with patients in a helpful and polite manner; and they gave examples of how they had sensitively supported patients to receive a caring service.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 97 completed cards and 91 comments were positive about the service experienced. Most patients felt the practice offered an excellent service and that staff were efficient and genuinely cared. 32 out of 97 comment cards included less positive feedback and common themes related to phone access, the appointment system and continuity of care. We also spoke with six patients on the day of our inspection. All but one told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We received positive feedback from two care homes providing care for older people. The care home managers praised the practice staff for having a friendly, helpful and caring approach towards the residents. The GPs were described as being very patient with the residents and ensured continuity of care by maintaining weekly visits. GPs were also noted for communicating with specific individuals in accordance with their care plans and preferences. This was particularly important for some of the residents with dementia to ensure person centred care.

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

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

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area and practice website stating the practice's zero tolerance for abusive behaviour.

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

The survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example the national patient survey results showed: 85% of practice respondents said the GP involved them in care decisions, 84% said the last GP they saw or spoke to was good at giving them enough time and 86% felt the GP was good at explaining treatment and results.

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

Good

# Are services caring?

We were shown three examples of care plans to evidence that practice staff involved patients in the planning and delivery of their care. This included care plans for people with a learning disability, receiving end of life care and at risk of hospital admission.

The care plans showed each patient's care needs had been reviewed in recognition of their changing needs and reflected the current treatment and / or support provided. This was also supported by meeting minutes reviewed which showed the practice discussed care planning arrangements with other professionals such as care home managers, the community matron, district nurse and Macmillan nurse.

The 2013/14 QOF data showed the practice had achieved percentages above the national averages for the review and care planning arrangements for people with mental health needs, diabetes and dementia. For example: 96% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record in the preceding 12 months; and 69% of patients on the mental health register had an agreed care plan as at 06 February 2015.

Staff told us translation services were available for patients who did not have English as a first language. This ensured patients could express their views and be involved in making decisions about their care, treatment and support. We saw notices in the reception areas informing patients this service was available.

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

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 80% of 118 respondents to the national patient survey said the last GP they saw or spoke to was good at treating them with care and concern.

The patients we spoke with and most of the comment cards we received were also consistent with this survey information. These highlighted that staff responded compassionately when patient's needed help to access support services to help them manage their treatment and care when it had been needed.

The practice had good systems in place to identify and support carers to ensure their needs were taken into account. For example, the practice's computer system alerted GPs if a patient was a carer and they were actively signposted to the staff member with a lead role of being a carers' champion. This ensured that each carer's physical and mental health needs were not overlooked as a result of their caring responsibilities. Some staff we spoke with also recognised the support needs of young carers.

The practice staff, patient participation group (PPG) and Carers Federation had worked in partnership to hold a carers event on 25 and 27 March 2014. A support worker for adult carers was available to provide information and records reviewed showed referrals for support were made as a result. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us if families had suffered a bereavement, their usual GP contacted them. This call was either followed by: a patient consultation at a flexible time and location to meet the family's needs; or by giving them advice on how to find support and / or counselling services. The practice website also included information for patients of what action to take in times of bereavement.

Patients were able to access information on a number of support groups and organisations from the practice website and notices were available in the waiting room. These included information on counselling services, carers direct, Alzheimer's society and the mental health foundation.

The practice staff recognised isolation as a risk factor and worked with other professionals to address this and / or make appropriate referrals for support. This included older people, people with mental health and people with learning disabilities. People with long-term conditions were also assessed for anxiety and depression to ensure they received appropriate support. The practice QOF data showed 80% of patients on the depression register had received a review of their needs as at 06 February 2015.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The practice engaged regularly with the NHS England local area team, Rushcliffe clinical commissioning group (CCG) and other practices, to discuss local needs and service improvements that needed to be prioritised. We saw records of where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice worked collaboratively with other health services and regularly shared information to ensure timely communication of changes in patient's care and treatment. This included information on patients that had attended services such as out of hours, accident and emergency, and hospitals.

Multidisciplinary meetings were held every two months to discuss patients on the palliative care register and patients with long term conditions visited by the district nurse, Macmillan nurse, community matron and chronic obstructive pulmonary disease (COPD is a collection of lung diseases) team. This helped to ensure that patients and their families received coordinated care and support.

Feedback received from two care home managers showed the elderly residents were promptly seen when required and had their care needs and medicines regularly reviewed. The care home managers felt the weekly home visits enabled the GPs and community matron to provide a personalised approach in dealing with the residents care needs. Both services had named GPs, which provided continuity of care and treatment.

The practice management held regular meetings with nursing home staff to review any hospital admissions and to assess if this could have been avoided. The meetings facilitated effective communications to ensure that patients' received appropriate treatment.

A wide range of health services were offered at the practice to meet patients' needs. For example, the practice worked closely with the midwife and health visitor to provide ante-natal care, baby clinics and immunisation services for children. Other services included family planning and contraceptive devices, health promotion, travel vaccinations and minor surgery.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. For example, the practice installed a new phone system with additional lines in response to patient feedback. Patients had reported being unable to get through to the surgery on the phone and hearing a constant engaged tone.

### Tackling inequity and promoting equality

The practice had recognised the needs of different population groups in the planning of its services. This included services for people with a disability or impairment, people whose first language was not English and university students. For example, the practice supported three care homes for residents with a learning disability, behavioural and / or mental health needs. Staff undertook home visits where the patients felt more at ease and provided photographs of key staff and the practice premises for reassurance.

The practice premises were purpose built and had been adapted to meet the needs of patients with disabilities. Services for patients were on the ground and first floors, and lift access was available. The premises were spacious and accommodated patients with wheelchairs and mothers with prams.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. A hearing loop for use by people with a hearing impairment was also in place. A GP reported this did not work well in some areas of the practice and this was being looked into at the time of our inspection.

The majority of the practice population spoke English and the practice could cater for different languages through translation services. Students were registered as temporary patients when they returned home during university holiday breaks and needed medical assistance. Staff told us people who lived within their practice boundary could easily register with the practice and an open list was maintained. This was also confirmed by a new patient we spoke with on the day of our inspection.

There was a system in place for flagging vulnerability in patient's individual records and a register was maintained

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

for adults and children living in vulnerable circumstances. We saw evidence of partnership working with other health and social care professionals to support the needs of the most vulnerable patients.

The practice provided equality and diversity training through e-learning. Some of the staff we spoke with confirmed completing the equality and diversity training in the last 12 months; and that equality and diversity was discussed at staff appraisals and team events. This was reflected in the training records reviewed which showed most of the staff had completed the training. We were told this would be closely monitored post our inspection to ensure all staff completed the training.

### Access to the service

Comprehensive information was available to patients about appointments in the practice leaflet and newsletter. This included how to arrange urgent appointments, home visits and how to book appointments through the website. Patients were able to book an appointment in person, by telephone or on line.

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

Most patients we spoke with were satisfied with the appointments system and were able to obtain an appointment or a telephone consultation, where needed. Some patients felt improvements were required in respect of the availability of non-urgent appointments, in particular if they wished to see a specific GP. This was aligned with our findings when we reviewed the appointment system. For example, to obtain an appointment with a senior partner meant a three week wait on average and a two week wait with any GP for non-urgent appointments.

This was further supported by the January 2015 national patient survey results. For example: 38% of respondents were able to see or speak with their preferred GP; 67% described their experience of making an appointment as good and 95% said the last appointment they got was convenient.

These findings were discussed with the practice management who acknowledged improving patient access was already a part of their quality improvement work. We were shown records to evidence changes made to phone access and the appointment system over the last three years in response to patient feedback. This included increasing the number of GP sessions in October 2014, introducing a telephone triage system, as well as a nurse triage service for minor illnesses.

We found the practice staff understood patients' need for improved access and systems were in place to continually review the way services were delivered in liaison with the PPG. For example, the PPG had been involved in testing the online system for booking appointments and requesting prescriptions before it was used by patients.

The management told us they were considering additional improvements but a date for commencing this had yet to be agreed. For example, offering GP appointments one evening a week and extending the opening hours over lunchtime three days a week. These improvements were in recognition that the current opening times did not enable some working age patients to attend early morning or late evening appointments with the GP. GP appointments excluding home visits were available from 9:00am to 11:40am and from 3:00pm to 6:00 pm on weekdays.

Overall, we found the appointment system was flexible to meet the needs of patients from different population groups

and staff offered patients a choice of appointments where possible. For example, longer appointments were available for patients with mental health needs and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a specific day each week, by a named GP and to those patients who needed one.

Staff we spoke with gave specific examples of where the practice had accommodated patient's requests. For example, arranging nursing appointments outside the normal surgery / clinic times and avoiding booking appointments at busy times for people who may this stressful.

The practice also supported patients who had been on long-term sick leave to return to work by providing statement of fitness for work (fit note) where appropriate. The fit note helps employees return to work sooner by providing more information about the effects of their illness or injury to their employer.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available to help patients understand the complaints system. This included a practice leaflet and posters displayed in the waiting room and on the practice website. Most patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a formal complaint about the practice.

The practice manager was responsible for handling complaints with the support of the senior GP partner. Records reviewed showed the practice had received 12 complaints in the last 12 months. We found the complaints were satisfactorily handled, and dealt with in a timely way. This also included working closely with other services such as NHS England and the local pharmacy. We saw that appropriate action had been taken in response to the complaints and where appropriate an apology letter was sent to the complainant.

Staff told us there were encouraged to raise concerns and an open culture was promoted. They also confirmed that lessons learned from complaints were shared as a team, and acted on to improve the service for patients. For example, as a result of a delay in processing a patient's referral, the procedures were changed to ensure administrative staff tracked and received an acknowledgement for any referral sent via email.

The practice reviewed complaints each year to detect themes or trends. The annual review of 2014 complaints was discussed at a practice business meeting held on 15 December 2014 and certain themes had been identified.

For example, three out of seven complaints for the medical team related to the attitude of a locum GP. This feedback was used to assess the locum GP's practice and a decision was made to terminate their services. The recruitment agency was also informed of the complaints to ensure this was used in the locum staff's appraisal.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good health and wellbeing for its patients. This included: the delivery of person centred care; with emphasis on a holistic approach to assessing patients' individual needs; and collaborative working amongst staff. Most of the patients we spoke with confirmed the delivery of this vision was evident in the care they received.

We found the management team were in the process of reviewing the vision, practice values and business plan, to ensure they were relevant to services currently provided. The review process had been prompted by changes in key staff and patient feedback. For example, staff changes included the retirement of a long standing GP partner in September 2013, and the recruitment of a new GP partner and practice manager in October and November 2014 respectively.

The management team had a clear understanding of the challenges facing the practice and ideas for improvement had been recorded and were being explored. This included improving patient access and education, maintaining continuity of care where possible and the delivery of community services from the practice.

Staff we spoke with knew what their responsibilities were in relation to the existing practice values. This included: having patients' needs at the heart of everything they did; offering a friendly and caring service to all patients; as well as listening and acting upon patient feedback to improve the service.

### Governance arrangements

The practice had a number of policies in place to govern activities and support staff in the carrying out of their duties. These policies and procedures were available to staff on the desktop on any computer within the practice. Staff we spoke with knew where to find these policies if required. They confirmed that policies and procedures were sometimes discussed in staff meetings to promote awareness.

We noted that polices relating to infection control and prevention required updating to ensure there were relevant to the practice and this was discussed with the management. However, most of the policies and procedures we looked at had recently been reviewed and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The 2013/2014 QOF data showed the practice was performing in line or above the Clinical Commissioning Group (CCG) and England averages in 17 out of 20 clinical domains assessed. They had had achieved a total score of 95.8%. Staff told us QOF data was regularly discussed at management and GP review meetings; and records we reviewed confirmed this.

Staff worked with neighbouring GP practices to measure its service against others and identify areas for improvement. This local peer review system was also supported by the Rushcliffe CCG which produced reports for comparison amongst the practices to support their quality improvement work. This included areas such as prescribing of anti-depressants, outpatient attendances and emergency admissions to hospital.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits had been undertaken in respect of cervical smears, diabetic needle cost and a range of medicines. Following each clinical audit, changes to treatment or care were made where needed.

The management team told us risks were regularly discussed at their meetings; including agreeing mitigating actions to ensure the safety of patients and staff. However, the recording of these discussions to evidence that action plans had been produced and implemented needed strengthening to ensure effective systems were in place for risk assessing the environment and clinical activity.

### Leadership, openness and transparency

There was a clear leadership structure in place with named members of staff in lead roles for both clinical and non-clinical areas within the practice. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding.

The practice manager and support services manager had lead in roles in the administration of the practice including finance management. We found management responsibilities were clearly defined and staff told us this ensured the practice was well managed.

# Are services well-led?

Good

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

The management team held weekly business meetings to discuss practice development issues, governance and performance; as well as measure progress against agreed actions. We found good communication systems were in place to ensure that staff received essential information about the planning and delivery of the service; as well as changes. This was facilitated through a range of various meetings including quarterly practice meetings, email correspondence and informal discussions.

We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us that there was an open culture within the practice. We were also shown the staff handbook that was available to all staff, which included sections on whistleblowing, equality and harassment and bullying at work. Staff we spoke with told us they had no concerns in respect of these areas.

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

The practice had an active patient participation group (PPG) with a committee of eleven 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 held meetings every six weeks and meeting minutes are available on the practice website for review.

The practice had introduced a virtual group to enable young people, those who worked or were unable to attend meetings to comment on issues that had been discussed by the committee. A quarterly newsletter was also available to patients and this included information relating to the practice and wider community activities.

We found there were high levels of engagement between the practice and the PPG to ensure patient feedback was used to improve the services. For example, the PPG members led in promoting the family and friends test within the practice. A rota system had been developed to ensure a PPG member was in attendance at the practice to encourage completion of these forms between 08 and 22 December 2014.

The impact of the PPG's involvement resulted in 247 forms being completed during this period and 91% patients said they would recommend the practice. PPG group members spent most part of the day during this event and others; and this was above and beyond their commitment. The PPG committee members also attended fortnightly meetings with other PPG members from 16 local practices to share ideas and drive improvement in their practice.

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the last annual patient survey dated 2012, which over 300 patients completed. The survey results showed the reception area did not provide enough privacy and patients conversations could be overheard. In response to this, reception staff received additional training in handling personal patient information and a sign was cited in the waiting room asking patients to wait until the reception desk was available.

It had been jointly agreed between the practice and the PPG not to conduct a formal patient survey in 2013/14 due to the transitional GP team. During this period patient feedback was gathered through the website, practice comments box, PPG suggestion box and other PPG activities such as the patient participation awareness week held between 01 and 08 June 2014.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Two reception staff told us they had not had the opportunity to attend reception meetings since August 2014. We found records were not available to show that regular meetings had been held in the last 12 months and this was acknowledged by management.

However, the practice had addressed this by sharing the 2015 meetings plan with all staff to ensure they were aware of the future dates for the meetings they were supposed to attend. The practice manager told us they were looking to establish regular meetings for the administrative staff. Staff told us that each month they were provided with sandwiches as part of a breakfast club by the practice leadership as an appreciation of their work.

### Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals had taken place for staff that had in been post

# Are services well-led?

Good

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

for over a year and a personal training plan was included. The training plans were detailed and included the staff member's development goals, the training and support required and the review arrangements.

Staff told us the practice was very supportive of training and they had protected learning time each month. Records reviewed showed a nurse building team was held on 30 August 2014 and they discussed clinical areas such as immunisation and vitamin B12 uptake rates and anaphylaxis.

The practice is a training practice for GP registrars and F2 trainee doctors (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine); and one of the former registrars is now working as a GP at the practice.

The practice had completed reviews of significant events and other incidents. These reviews were shared with staff at practice meetings to ensure the practice improved outcomes for patients. For example, records showed that appropriate learning and improvements had taken place to ensure the correct labelling of blood samples and procedures for accepting urine samples.