Rainworth Surgery

Inspection report

Rainworth Primary Care Centre
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Date of inspection visit: 17 April 2018
Date of publication: 30/05/2018

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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This practice is rated as good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Rainworth Surgery on 17 April 2018. This inspection was undertaken following the partnership's registration as a new provider with the Care Quality Commission (CQC) on 15 May 2017. The inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions 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.

At this inspection we found:

- The practice mostly had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. The practice needed to ensure that all appropriate events, including near misses, were reported to maximise learning opportunities.
- The practice reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were mostly able to access care when they needed it. Patients provided positive feedback on the GP triage system which had been introduced in 2016.
- Staff appraisals were up to date and staff were encouraged and supported to develop their skills and enhance their role.
- The practice had a higher proportion of patients with a long-term condition and older patients. We saw that the practice achieved good outcomes for these patient groups, demonstrated for example by their performance on the Quality and Outcomes Framework (QOF).
- Staff told us that it was a good place to work and that they felt valued and supported. They said that GP partners and managers were visible and approachable.
- The practice had recently completed a demerge process with another GP practice, and we saw this had been managed well with no disruption to patients.
- The partnership had considered future succession planning arrangements for the practice. They worked with their Clinical Commissioning Group (CCG) to consider forward planning to meet the needs of their patients.
- Healthcare professionals who worked with the practice provided us with positive experiences about their interactions with the practice team and told us they were caring, responsive and patient focused.
- Staff had the skills, knowledge and experience to carry out their roles effectively although the practice was not able to easily evidence this by means of an up to date training matrix. The practice finance manager was working to update this.

The areas where the provider **should** make improvements are:

- Review the practice training programme and ensure that staff have completed the training modules required for their roles and updates are undertaken at specified intervals.
- Promote the uptake of incident reporting, including near misses and positive event reporting, to all team members.

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and an expert by experience.

Background to Rainworth Surgery

Rainworth Surgery () is registered with the CQC as a GP partnership with three GP partners. The registered provider's name is Dr Huggard and partners. This inspection was undertaken as the partnership was newly registered with the CQC in May 2017 following a demerger with another local GP practice.

The practice has a population of approximately 6000 registered patients. Patients are predominantly of white British origin with only 2% of patients being from BME groups. The age profile of registered patients is mostly in line with local and national averages, but with a slightly higher percentage of older patients in comparison to national averages. The practice has 20% of their patients aged 65 and over, in comparison to a national average of 17%. The practice serves a population that is ranked in the fifth more deprived decile for deprivation. This is similar to the national figure but higher than across the wider CCG area. Rainworth is a former mining area which has contributed to a generally higher prevalence of long-term conditions, notably chronic obstructive airways disease. The practice has 62% of their patients with a long standing health condition in comparison to the CCG average of 56%, and the national average of 54%. However, recent and ongoing residential developments in the area are likely to create a move to a younger age profile.

Rainworth Surgery provides primary care medical services commissioned by NHS England and NHS Newark and Sherwood CCG. The practice is situated in the village of Rainworth in the north of Nottinghamshire. It operates from a purpose built primary care centre constructed in 2007 which includes an independent pharmacy and acts as a base for local community health services.

The clinical team consists of three full-time female GP partners, two practice nurses, and two healthcare assistants. The clinical team is supported by a practice finance manager, an administration manager, a location manager and a team of seven reception, secretarial and administrative staff.

Rainworth Surgery is not a training or teaching practice for medical or other health care students or post graduates.

The practice opens from 8am until 6pm Monday to Friday, with extended opening hours for pre-bookable appointments once a month on a Saturday morning from 8.30am until 12.30pm. Scheduled GP appointment times are available each morning from 8.30am to 12 noon and each afternoon 2pm to 5.30pm. Patients can access evening appointments between 6.30pm-8pm in extended access hubs at GP surgeries in Blidworth and Clipstone.

These can be booked by Rainworth Surgery reception staff and are available for urgent GP appointments and pre-bookable appointments with a nurse or health care assistant.

The surgery closes for one afternoon on most months to facilitate staff training. When the practice is closed, patients are directed to the out of hours' provider via the 111 service.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. Staff had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report safeguarding concerns. Safeguarding meetings were held every three months. Any patients who were discussed at the meeting had their clinical record updated contemporaneously to ensure all clinicians had access to the most recent information.
- Staff who acted as chaperones were trained for their role and had received a DBS check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The three GP partners worked full time following the retirement of a fourth partner in 2015. The GPs worked closely together to ensure adequate cover at all times and told us they had only used a GP locum on one occasion. Two experienced locum nurses were working regularly at the practice at the time of our inspection to cover maternity leave and study leave for the two practice nurses.
- There was an effective induction system for staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- There was a robust monitoring process for patients prescribed high risk medicines.
- A CCG pharmacist worked closely with the practice to offer support and advice on all issues relating to

Good

Are services safe?

medicines management. The pharmacist described an excellent working relationship with the practice and told us that staff were committed to delivering the best care to their patients.

Track record on safety

The practice had a good track record on safety.

- There were some risk assessments available in relation to safety issues. The practice finance manager was looking to develop these further.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Most staff understood their duty to raise concerns and report incidents and near misses. GPs and managers supported them when they did so. However, we found that not all staff were considering when things should be reported to maximise learning opportunities. For example, we were told about a change to the child immunisation schedule which was not implemented at the right time and eight children therefore did not commence the revised programme. Parents were informed and there was no risk to safety. We were assured effective actions had been taken to address this within the practice although it had not been recorded as a significant event.
- There were systems for reviewing and investigating when things went wrong and were reported. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Leaning was discussed at practice meetings and was also shared via notifications on the computer system.
- The practice acted on patient and medicine safety alerts.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services.

Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.

Effective needs assessment, care and treatment

Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Templates on the practice computer system linked with guidance to ensure care was provided in accordance with current evidence-based practice. Any new or revised guidance was discussed at monthly clinical meetings.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients. A community-based chronic pain specialist was available to see patients in the practice for assessment. This was provided through a home visiting service being commissioned by the CCG.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received an assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of their prescribed medicines.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice held monthly multidisciplinary team (MDT) meetings with the community matron, district nurses, social workers, clinical nurse specialists, palliative care nurse, physiotherapists and occupational therapist to discuss those patients with complex patients, including those at end-of-life. This ensured that all members of the MDT were involved in delivering the best possible holistic care to patients.
- The practice visited patients in nearby nursing homes when requested and provided annual reviews as appropriate. This included patients who had dementia.
- The practice had access to the CCG funded service 'Call for Care' which enabled patients at risk of hospital admission to receive a holistic assessment of their needs within two hours. Where possible, services such as physiotherapy could be organised to meet that individual's needs to keep them safe in their own home.
- The practice offered flu vaccinations at set clinics, during long-term condition reviews and opportunistically. They also had good uptake for shingles vaccinations.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GPs worked with other health and care professionals to deliver a coordinated package of care.
- GPs and nursing staff had lead roles in long-term condition management. Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, the practice nurse had completed a Certificate in Diabetes Care (CIDC) course.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- Outcomes achieved for long term conditions from the most recently published QOF data for 2016-7 showed achievement was mostly comparable to other practices. However the practice achieved significantly higher in respect of:
- 88% of patients on the practice asthma register had received a review in the preceding 12 months including an assessment of asthma control using three Royal College of Physicians (RCP) recommended indicators (CCG average 80%; national 76%), An asthma annual review questionnaire was available on the practice website which could be submitted without attending

the practice; this identified any issues that required follow up. Any patient who had concerns or whose condition was deteriorating was advised to attend the surgery for their review.
- 91% of patients with hypertension had a blood pressure reading taken in the last 12 months which was 150/90 mmHg or less (CCG average 86%, national 83%)
- Patients who are newly found to be pre-diabetic are all offered referral to a structured education programme to encourage healthy lifestyles and improve understanding of their condition.
- The CCG pharmacist assisted with medicines reviews and ensured the practice adhered to local and national prescribing.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above. The practice achieved significantly higher for children aged one with a completed course of 5:1 vaccine at almost 99%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care, or for immunisation.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The lead safeguarding GP attended quarterly safeguarding meetings with the health visitor who liaised with other relevant members of the multi-disciplinary team.
- The practice adhered to national guidance on determining a younger person's capacity to consent when consulting with them (for example, contraceptive advice)

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

- The practice's uptake for cervical screening was 77%, which was in line with the 80% coverage target for the national screening programme. The practice had systems in place to check uptake and to recall non-responders.
- The practices' uptake for breast and bowel cancer screening was generally in line with local averages and above the national averages.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. This was promoted within the surgery and on the practice website during the summer, and text message reminders were also used to increase attendance.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. This included sharing appropriate information with the out of hours provider for example, to ensure the patient received the right care promptly in line with their preferences.
- The practice held a register of patients with a learning disability. They provided care to several local care facilities for adults with a learning disability.
- The practice offered annual health checks to patients with a learning disability. The practice was able to demonstrate that 60 patients (98% of those patients on their learning disability register) had received an annual review of their health needs during 2016-17.
- Staff were aware of what to do and who to contact regarding adult safeguarding concerns and were able to recognise signs of abuse, staff had been trained and were aware of the lead GP.
- The practice had a policy for the homeless and would accommodate any individuals or families living in vulnerable circumstances including those with no fixed abode and members of the travelling community.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, and

access to 'stop smoking' services. There was a system for following up patients who failed to collect prescribed medicines, or attend for the administration of long term medication.

- Outcomes from QOF showed that 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was significantly higher than the CCG average of 83% and above the national average of 84%. These reviews would be undertaken by a GP in the patient's home when this was required.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was in alignment with local and national averages.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was significantly above the local and national averages.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. Dementia risk assessment carried out annually on all patients with long-term conditions.
- Advanced care planning was in place for patients with dementia
- Letters received from Accident & Emergency and the out-of-hours service were reviewed on a daily basis and assessed in terms of any immediate follow up care required.

Monitoring care and treatment

The practice provided some evidence of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- QOF results for 2016-17 showed an overall achievement of 97.8% compared to the CCG average of 98.03%, and a national average of 96.4%. The practice provided information (subject to external verification) that this performance had been maintained with an achievement of over 95% for 2017-18.
- The overall exception rate was in alignment with local and national averages. However, these were significantly higher for cancer, dementia, osteoporosis and cervical screening. The practice explained exception reporting was undertaken further to a patient's failure to respond to three review request letters, but were unable to be more specific on why these indicators were particularly high.
- The practice was involved in quality improvement activity. For example, we saw some evidence of a clinical audit programme. Two prescribing audits were ongoing at the time of our inspection. We were provided with one example of a completed audit cycle. This related to patients prescribed direct oral anticoagulants (DOACs) to help prevent blood clots and reduce the likelihood of developing serious conditions such as strokes and heart attacks. Local prescribing guidance stated that these patients needed to have creatinine levels checked by a blood test to check kidney function either annually or every six months depending on the levels. The second audit demonstrated that 89% patients were receiving appropriate monitoring (the first audit had shown 65% compliance) following actions including a review of the recall process. Further actions were agreed after the second audit to ensure continued improvement and meet the standard of 100%.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Records of skills and qualifications were maintained, although staff training records required some updating.
- Staff were encouraged and given opportunities to develop. A practice nurse was undertaking university based training to become an advanced nurse practitioner. The two-year course was planned to enhance skill mix and prescriber levels in the future. There were plans for healthcare assistants to qualify in wound care management to allow nurses to focus on more complex nursing issues. The practice also supported non-clinical apprenticeships.

Good

Are services effective?

- The practice provided staff with ongoing support. This included an induction process, appraisals, clinical supervision and support for revalidation. The induction process for healthcare assistants was in the process of being revised to include the requirements of the Care Certificate.
- Non-clinical staff rotated roles so that all key tasks could be covered as a small team, as well as aiding skill development for individuals. Staff still retained dedicated areas of responsibility and had a 'buddy' system to ensure continuity.
- There was a procedure for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community and social services for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. A notice board in the reception area focused on monthly topics to promote good health or provide information.
- The practice offered NHS health checks and new patient checks.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice told us that some of the practice team had undertaken training on the mental Capacity Act, whilst others were in the process of completing this before the end of April.
- The practice monitored the process for seeking consent appropriately.

Please refer to the Evidence Tables for further information.

Good

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural and social needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids (for example, a hearing loop) and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The latest results from the national GP patient survey showed that patients felt that they were involved in decisions about their care and treatment. Results were comparable to other GP practices.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

Please refer to the Evidence Tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice undertook home visits to patients unable to attend the surgery for acute medical problems as well as for chronic disease management. They also offered flu jabs to housebound patients.
- Primary Integrated Community Services (PICS) had a base within Rainworth Primary Care Centre. This CCG commissioned service consisting of advanced nurse practitioners and emergency care practitioners provided an acute home visiting service aimed at avoidance of hospital admission.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with members of the wider local community health and social care teams to discuss and manage the needs of patients with complex medical issues.
- The practice worked closely with the community matron and the community respiratory and heart failure teams to ensure patients received the appropriate high quality care. The community diabetes nurse was based at the health centre and was therefore easily accessible to discuss any queries about patients. This nurse held a weekly clinic on site for insulin initiation and those to see those patients with more complex needs, and this service was offered to all patients within the CCG area who resided locally.
- The practice offered longer appointments and home visits as needed to meet the needs of this group.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The GP triage system provided responsive care for children and younger people. It ensured all children could be assessed initially on the phone that day. Those who needed to be seen by a clinician were given an appointment to be seen that day.
- The practice worked with an assigned midwife. The midwife saw patients in the practice every Thursday or would arrange to see them at home
- The practice carried out eight-week mother and baby checks.
- The practice offered contraception advice, and participated in the C-Card scheme (the provision of free condoms to teenagers and young people). The practice also provided family planning services including coil and implant fittings.
- The practice could offer appointments outside of school hours', or telephone calls if needed, to accommodate children at a convenient time.

Working age people (including those recently retired and students)

- The practice offered pre-bookable extended opening hours on a Saturday morning once a month. Evening appointments were available until 8pm at one of the nearby extended hours hub sites.

Good

Are services responsive to people's needs?

- The practice has recently commenced appointments with the practice nurse for travel vaccinations
- Same day telephone triage was offered and the practice told us that since introducing this system, A&E attendance rates for their patients had decreased. CCG data demonstrated that this had made an impact.
- The practice provided examples of how the triage service had impacted on patient care. For example, a patient rang the surgery with the recurrence of a previous health problem. The GP discussed this with the patient and arranged for them to be seen by a specialist at the hospital later that day. This enabled rapid and effective treatment on the same day without having to see the GP.
- The practice offered telephone appointments when appropriate. For example, medicines reviews; discussion of hospital letters; test results.

People whose circumstances make them vulnerable:

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Patients and their families were signposted to local services to help support them with alcohol or substance abuse.
- The annual review of patients with a learning disability or dementia could be arranged on the monthly Saturday morning session when the surgery was quieter.
- A GP told us how they had helped a teenage patient with a learning disability to engage with social activities in the local town, and provided information on how to access this.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. We saw some evidence of dementia awareness training but other staff needed to undertake this training module.
- The practice provided patients with details on self-referral to local counselling services and other services to promote good mental health.
- The practice worked with the local mental health crisis team, community psychiatric nurses, carers, the dementia outreach team and social care to meet the needs of their patients. The practice told us how they had responded to keep a patient expressing suicidal thoughts safe and in receipt of urgent care and support.
- The practice had a named dementia champion who was able to signpost carers to appropriate support services.

Timely access to care and treatment

Patients were mostly able to access care and treatment from the practice within an acceptable timescale for their needs.

- There was flexibility inbuilt into the system, for example, to see more patients on a Monday to accommodate demand. The GP triage system also meant that more on-the-day appointments could be offered.
- Patients with the most urgent needs had their care and treatment prioritised.
- The practice offered online booking for appointments and the ordering of repeat prescription.
- Patients mostly reported that the appointment system was easy to use. On the day of the inspection, there was a waiting time of approximately three weeks for a routine GP appointment. Patients could usually book up to six weeks in advance.
- The practice used an automated appointment text reminder system to help reduce DNA (did not attend) appointments. The practice planned to develop this area further to enable better two way interactions with patients.
- Patients could access evening appointments between 6.30pm-8pm in extended access hubs at GP surgeries in Blidworth and Clipstone. These could be booked by Rainworth Surgery reception staff and were available for urgent GP appointments and pre-bookable appointments with a nurse or health care assistant.

Outcomes from the most recent GP patient survey, published in July 2017, showed that patient satisfaction in relation to access to the service was mostly comparable to other practices. However, the percentage of respondents who were 'very satisfied' or 'fairly satisfied' with the practice opening hours at 63% was lower than the CCG average of 79% and the national average of 80%. The practice told us that the monthly Saturday morning session, and access to a GP in the local extended hours' service until 8pm, provided some alternatives for patients. There were however, no plans to review the opening hours at the time of our inspection.

Good

Are services responsive to people's needs?

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the Evidence Tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The partners were supported by a management team consisting of a practice finance manager (appointed in autumn 2017), a location manager, and a data quality/IT manager.
- GP partners and the practice finance manager were knowledgeable about issues and priorities relating to the quality and future of services. Business meetings were held monthly.
- The partners and managers were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including succession planning arrangements for the practice.

Vision and strategy

The practice was able to articulate a clear vision to deliver high quality, sustainable care.

- The practice had merged with another local GP practice in 2015 as part of longer-term sustainability programme, prompted by the retirement of one of the partners. However, the partners at Rainworth Surgery did not feel the arrangements provided the intended benefits and considered their own leadership and experience was sufficient and strong enough to meet their needs. The practice subsequently demerged in May 2017, and the partners explained the advantages this gave them in terms of flexibility, stronger communication, and the ability to decide their own future plans. The practice told us about the challenges that the legacy from the demerge process has posed and how this had been their focus over the first few months.
- Whilst there was not a written set of values or a mission statement, we did see some objectives that had been developed for the service. These focused on the delivery of high quality services provided in an empathetic manner, working in collaboration with the wider health care team. The practice had formulated a business development plan in September 2017.
- The practice finance manager told us that the practice was planning to agree a vision and strategy with the practice team's involvement.
- Staff we spoke with understood the practice's objectives and how they contributed towards their achievement.
- The practice planned its services to meet the needs of the practice population and was in line with health and social priorities across the region. One of the GPs was a member of the CCG Board and was therefore able to contribute to the local decision-making process.

Culture

The practice had a culture of high-quality sustainable care.

- The practice focused on the needs of patients.
- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were given protected time to support their professional development.
- There was a strong emphasis on the safety and well-being of all staff. We were told how managers had been highly supportive to members of the team throughout difficult personal circumstances. This included time off work and flexible working arrangements.
- The practice promoted equality and diversity and had a policy to support this. Some staff had received equality and diversity training, but we saw that others still needed to complete this training module. Staff told us that they felt they were treated equally.
- There were positive relationships between staff and individuals/teams who worked with the practice.

Governance arrangements

Good

Are services well-led?

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were established, understood and effective. This included a scheduled timetable of practice meetings.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of performance and enabled corrective actions to be taken if required
- Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The practice used information to assess performance and to take corrective actions if these were indicated. The practice had a quarterly meeting with their CCG to discuss performance. We saw information provided by the CCG that showed no significant concerns with the practice's recent performance.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. A patient participation group was in place.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for continuous improvement and innovation.

- The practice was able to demonstrate how they reviewed service delivery and planned effectively for the future. This included the practice nurse undertaking training to become an advanced nurse practitioner.
- The practice engaged with the CCG and supported developments including the acute home visiting service.

Please refer to the Evidence Tables for further information.