# The Windmill Practice

## Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Outstanding |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at The Windmill Practice on 11 May 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events and near misses, and we saw evidence that learning was applied.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, education courses for patients with long term conditions such as diabetes and working with the local diabetes specialist nurse to improve the wellbeing of patients.
- There was easy access to appointments for patients whose circumstances made them vulnerable, for example homeless patients, asylum seekers and patients from the traveller community. They were assured of an appointment on the day when they presented to the practice without a booked appointment.
- Feedback from patients about their care was consistently positive. Data from the GP survey was consistently high.
- The practice planned and co-ordinated patient care with the wider multi-disciplinary team to plan and deliver effective and responsive care to keep vulnerable patients safe.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice actively reviewed complaints to see if there were any recurrent themes, and identified issues where learning could be applied to improve patient experiences in the future.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

# Summary of findings

- The practice had strong and visible clinical and managerial leadership and governance arrangements, and staff told us that they were well-supported and felt valued by the partners and the practice manager.

We saw areas of outstanding practice including:

- The practice was committed to working with people whose circumstances might make them vulnerable. For example, the practice had a long history of working with homeless patients across Nottingham and provided substance misuse clinics to their own registered patients and those registered as temporary residents. In addition to removing barriers for these patients to access services at the practice, they undertook outreach clinics in local hostels on a weekly basis.
- A number of GPs used their expertise to provide education to colleagues locally and nationally in areas such as substance misuse, domestic violence, child safeguarding and health management of asylum seekers.
- The practice demonstrated continuous improvement and innovation in leading on a number of pilot schemes within their Clinical Commissioning Group (CCG) which are now available as commissioned services, such as prostate cancer screening service for men of African Caribbean ethnic background, a community epilepsy specialist nurse and an urgent referral service to Welfare Rights.

**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.

- There was an open culture in which all safety concerns reported by staff were dealt with effectively, and a system in place for reporting and recording significant events.
- The practice had robust processes in place to investigate significant events and lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. There were designated leads in areas such as safeguarding children, domestic violence and infection control with training provided to support their roles.
- Risks to patients were recognised by all staff and were well managed. The practice had systems in place to deal with emergencies, and arrangements for managing medicines were robust.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

- Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients. For example, there were seven completed audits and some ongoing audits where results indicated improved and appropriate prescribing for patients.
- Data showed that the practice was performing in line with local practices on QOF. Patient outcomes for indicators such as heart failure and mental health were better than the local CCG averages.
- The practice had identified areas for improvement and was working to address these. For example, they worked with a community specialist diabetes nurse who carried out clinics for

# Summary of findings

the more complex patients with a diagnosis of diabetes resulting in improved outcomes for the patients. Practice supplied data indicated overall performance on diabetes had improved significantly in 2015/16.
- Staff worked effectively with multi-disciplinary teams to meet the range and complexity of people's needs. There were monthly meetings to discuss unplanned admissions as well as patients at risk of admission to hospital.
- Staff had the skills, knowledge and experience to deliver efficient care and treatment. Additional training was offered to staff on real life situations to improve their understanding of safeguarding children and vulnerable adults.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example, 89% of patients said the last GP they saw or spoke to was good at involving them in decisions about their care, compared to the CCG average of 81% and national average of 82%.
- Feedback from patients, carers, care homes and community health professionals was consistently positive about the way staff treated vulnerable patients. For example, GPs accommodated patients presenting at the practice without an appointment.
- Patients told us they were treated with care and concern by staff and their privacy and dignity was respected. Feedback from comment cards was overwhelmingly positive about the compassionate care given by the staff.
- Information for patients about services available was easy to understand and accessible.
- Views of external stakeholders were strongly positive and aligned with our findings.

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

Good

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example, the practice worked closely with the local homeless team and facilitated access for homeless patients. Additionally they provided weekly outreach clinics at local hostels.

# Summary of findings

- There were innovative approaches to providing integrated patient-centred care. For example, the practice responded to concerns about the poor uptake of hepatitis C treatment by redesigning their substance misuse clinics to include a specialist hepatitis C nurse who offered advice, testing and treatment to patients considered at high risk of the condition. A published clinical trial undertaken between 2005 and 2008 found the service identified a large number of patients with the condition, and the outcomes of treatment in primary care were comparable with those in a secondary care setting.
- Cervical smears were offered opportunistically to patients attending substance misuse clinics so they did not need to make separate appointments for the service. There was evidence showing improved uptake rates for this population group and the practice as a whole.
- The practice offered minor illness clinics provided by the nurses every day, who were able to prescribe if medicines were needed. Feedback from patients was very positive about access to see the nurses.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients. For example, improving the appointments system to solve problems identified with access.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- Extended hours appointments were available every second Saturday of the month to facilitate access for working patients.
- Vulnerable patients were encouraged to present themselves at the practice if they felt unwell and an appointment would be made available for them on the day.

**Are services well-led?**

**Outstanding** ☆

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

- The practice had a clear vision with quality and safety as a priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff at meetings and development away days.

# Summary of findings

- High standards were promoted and owned by all practice staff and teams worked together across all roles. There was no 'senior partner' view, with all GPs and the practice manager sharing responsibilities across the practice and encouraging staff to take on lead roles.
- There were regular team meetings held for the whole practice team and staff development away days were held in the past. Staff told us they felt well supported by the management.
- The practice demonstrated collaborative working with other organisations to support their most vulnerable patients and improve health inequalities, such as the local council, social welfare services, refugee groups, domestic violence support organisations and homeless services.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. Practice policies and procedures were actively reviewed and staff had a wide range of training resources available to them.
- The practice proactively sought feedback from staff and patients, which it acted on, including issues pertaining to appointments access.
- Staff had a wealth of skills and experience which were actively used to provide training to local health professionals in the Nottingham community and nationally. There was a high level of engagement with local organisations to improve the health inequalities and outcomes of vulnerable patients. For example, the practice worked closely with the local city council, refugee forums, social welfare services and food banks in providing a holistic approach to patient care and reduce barriers to accessing healthcare.
- The GPs and staff demonstrated a track record in driving improvements in services across the city by suggesting innovative services that have now been rolled out as commissioned services. Examples included a prostate cancer screening service for men of African Caribbean ethnic background, a community epilepsy specialist nurse for hard to reach patients and an urgent referral service to Welfare Rights.

# Summary of findings

## The six population groups and what we found

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

### Older people

Good

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

- The practice had a significantly lower elderly population with 10% aged over 65, compared to a national average of 17.1%. The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments by the GPs and nurses for those with enhanced needs.
- Feedback from a care and nursing home indicated that the named GP carried out weekly review visits and responded to urgent requests when needed to ensure continuity of care. They told us residents had care plans in place and the GP involved patients and their relatives in decisions about their care.
- They worked effectively with multi-disciplinary teams to identify patients at risk of admission to hospital to ensure their needs were met. For example, the practice coordinated care with the district nurse and community matron. There was evidence of close partnership working with other community teams co-located in the health centre such as the Falls and Bone team.
- The practice team had undertaken adult safeguarding awareness training and were looking to improve their knowledge of Deprivation of Liberties (DoLS) through joint training with their main care home.
- The practice offered annual health checks to patients aged 75 and over and performed the checks on request. They identified 336 patients aged over 75, and 299 patients were seen for a review of their blood pressure and/or long term conditions. All patients over 75 years old had a named GP for continuity of care.
- The practice reported the flu vaccination uptake for 2015/16 was 70%, in line with the CCG average of approximately 72% and higher than the average for practices in the same care delivery group of 65%.

### People with long term conditions

Good

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

- The practice was proactive in chronic disease management by having a recall system in place to invite patients with long term

conditions for at least one health check annually. This involved coordinated appointments with the health care assistant, followed by an appointment with the nurse or GP in one visit to discuss patients' needs.

- The practice achieved 89.6% on QOF in 2014/15. This was in line with the CCG average of 91.5% and the national average of 94.8%. The practice told us they their QOF performance had improved to 96.6% for 2015/16 (unpublished results), and attributed their success to the recall system. There was evidence of detailed reflection on their performance at the end of each year. Meetings were held with all clinical staff to analyse performance on each disease area and suggestions for improvements made.
- There were a large number of leaflets providing education and self-care advice and patients were directed to online resources. The practice actively encouraged patient education sessions for patients with conditions such as diabetes and chronic obstructive pulmonary disease, referring them to courses and the primary care education college. Feedback from patients indicated this had improved their health and understanding of their conditions.
- The practice promoted self-referral to services such as podiatry, physiotherapy and psychological therapies.
- Nursing staff worked collaboratively with a community specialist diabetes nurse on their more complex patients with a diabetes diagnosis to improve outcomes for the patients.
- QOF achievement on indicators for diabetes was consistently in line with CCG averages. For example, the percentage of patients with diabetes, on the register who had their cholesterol measured within the preceding 12 months was 81.4%, compared to a CCG average of 76.31% and national average of 80.53%. The practice supplied data indicating the number of patients with diabetes under poor control had reduced and their overall performance in diabetes had improved significantly in 2015/16, although the data has not yet been published.
- QOF achievement on indicators for atrial fibrillation and chronic obstructive pulmonary disease were broadly in line with national averages.
- Longer appointments and home visits were available and offered when needed.

**Families, children and young people**

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

Good

# Summary of findings

- The practice worked closely with midwives, health visitors and community nurses attached to the practice. There were systems in place 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 A&E attendances
- The practice held meetings every six weeks with the health visitor, and also reviewed any children on a child protection plan at their clinical meetings.
- Immunisation rates were broadly in line with the CCG averages for standard childhood immunisations. Vaccination rates for children under two years old ranged from 89.2% to 96.1% compared against a CCG average ranging from 91.1% to 96.3%. Vaccination rates for five year olds ranged from 84.5% to 94.8%, compared to the CCG average of 86.9% to 95.4%.
- Appointments were available outside of school hours with urgent appointments available on the day for children and babies.
- The practice offered a pregnancy pack to newly pregnant patients. A joint weekly baby clinic was offered with a GP, nurse and health visitor present. This allowed mothers and babies attending for the eight week check to have their post-natal check, baby check and first immunisation done in one visit.
- The practice offered a full range of family planning services including fitting of intra-uterine devices (coil) and contraceptive implant fitting.
- The premises were suitable for children and babies. Baby changing facilities were available and the practice accommodated mothers who wished to breastfeed. There were minor illness booklets offered to new parents.

**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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included access to telephone appointments, text reminders and the availability of early morning appointments from 7.30am to 8am on weekday mornings.

# Summary of findings

- The practice offered extended hours appointments every second Saturday of the month from 8.30am to 12.30pm with three GPs and a practice nurse available. An additional clinic was held from 7.30am to 8am every Tuesday with a practice nurse to cater for working patients.
- Appointments with the health care assistant were available from 7.40am for working patients in need of phlebotomy services. There were 27 appointments offered each week and the practice reported these were fully utilised.
- The practice was proactive in offering online services such as online prescription requests, appointments, and accessing medical records.
- There was a full range of health promotion and screening information in the practice and online that reflects the needs for this age group. Self-referral was encouraged for accessing psychological services, podiatry and physiotherapy.
- The practice hosted a Physio First service which allowed patients to see a physiotherapist within a week and did not require them to see a GP first. Physiotherapy clinics were offered twice a week on Wednesday mornings and Friday afternoons. Patients were encouraged to self-refer to this service. Practice supplied evidence indicated this was a popular service with appointments uptake ranging from 16 to 48 a month, and approximately 500 patients having used it between March 2015 and June 2016.
- There were joint injections offered by the practice.
- The practice's uptake for cervical screening for eligible patients was 82.9%, which was higher than the CCG average of 81.5% and the national average of 81.8%.

**People whose circumstances may make them vulnerable**

**Outstanding** ☆

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

The practice held a register of patients living in vulnerable circumstances, providing a non-judgemental, flexible and welcoming approach to ensure there were minimal barriers to accessing healthcare. The patients included homeless people, asylum seekers, travellers, Lesbian, Gay, Bisexual and Transgender people, people experiencing domestic violence, and people coming to the end of their life.

- The practice provided temporary and permanent registrations to all patients, encouraging the latter so that they are able to obtain their medical records and ensure continuity of care.

# Summary of findings

- The practice had identified that compliance with appointments was difficult for vulnerable people, so they encouraged these patients to present to reception whenever they felt the need for medical care and an appointment was offered to them on the day. GPs offered a holistic assessment at first contact with the patients, assessing their mental, physical and social needs to plan their care.
- There was evidence of liaison with hostels, support agencies, homeless nursing team, local housing department, and drug and alcohol services. The practice held quarterly multi-disciplinary health meetings for the homeless.
- The practice saw a significant number of asylum seekers, offering them 30-60 minute appointments for their first health check when they register with the practice. They actively used interpreters and Language Line for patients who could not communicate in English, and advised self-referral to language lessons. Referrals were made to local support agencies such as Refugee Forum and Refugee Action.
- There was proactive management of patients from the travelling community who were offered telephone advice by GPs if they were unable to travel to the practice. Patients were offered flexible registrations through the out of area registration scheme, and those with complex health needs were given care plans to present to any health professional seeing them outside of Nottingham.
- The practice offered a non-judgemental approach to patients from the LGBT community. They offered referrals to gender and HIV clinics, and a full range of sexual health advice and testing where appropriate.
- All staff had received domestic violence awareness training and two GPs at the practice were champions who used their role as trainers of domestic violence awareness to the wider GP community. There was evidence the practice actively advertised to patients that they were a domestic violence aware practice to encourage disclosure and offer support through referrals to a domestic violence counsellor who offered clinics within the practice as well as referrals to Women's Aid.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing and how to contact relevant agencies in normal working hours and out of hours.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. For example, the practice encouraged identification of carers to offer them support and provided food vouchers for a local food bank scheme.

# Summary of findings

- The practice provided good care and support for end of life patients, keeping them under close review in conjunction with the wider multi-disciplinary team. These included patients with end stage alcoholic liver failure.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. For example, the practice liaised with Carers Federation to identify carers and offer them support.
- The practice received training and advice from a learning disabilities facilitator, enabling them to offer annual health checks to patients identified as having learning disabilities. Staff told us they worked closely with key workers and offered longer appointments for patients.
- Staff told us they were aware of how to access interpreting and text talk services for their patients with hearing impairment. The self-signing in screen allowed patients to choose from different languages and receptionists presented patients with a list of languages to choose from if they could not speak in English, so that an interpreter could be arranged for them through Language Line. The practice recorded 75 different languages spoken by their patients. This represented 25.5% of their patients.
- Two of the GPs at the practice had additional training to become domestic violence champions, and a domestic violence counsellor attended the practice to offer support to patients and raise awareness.
- The practice offered an in house alcohol abuse clinic, promoting and referring to Last Orders alcohol service. They provided community detox and offered injections to patients supported at a local community alcohol detox unit.
- There were three GPs providing four shared care opiate dependence clinics every week with a drug worker and support worker, for patients with conditions relating to substance misuse. The practice ensured there was access to advice and support from the GPs on days when the clinics were not available.
- The practice proactively arranged health checks and reviews such as cervical smears, contraception and smoking advice to be undertaken when patients attend for methadone prescriptions to avoid making additional appointments which they may not attend. Practice supplied data indicated that of the 38 female patients seen in the substance misuse clinic in the last year who were eligible for a cervical smear test, 33 had undertaken the test, showing an uptake rate of 86.8% in that population group.

# Summary of findings

- A nationally recognised hepatitis C clinic was also offered in parallel to the substance misuse clinics offering testing, treatment and support to patients, with the assistance of practice staff.

**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, learning disabilities, alcohol and substance misuse).

- The practice offered annual health reviews with care plans in place for patients with dementia, working closely with key workers, relatives and other health professionals. Data showed that 80.4% of patients diagnosed with dementia that had their care reviewed in a face to face meeting during 2014/15. This was in line with the national average of 84.01%.
- Staff told us that of the 54 patients on the dementia register in 2015/16, and 42 had their care plans reviewed. This represented 79.2% of their register. The practice told us they carried out regular data quality checks to identify patients appropriate for annual reviews, which increased the number of patients offered health checks.
- The practice achieved 93.2% for mental health related indicators in QOF, which was 4.5% above CCG average and 0.4% above national average. The exception reporting rate was 19.2% (The exception reporting rate is the number of patients which are excluded by the practice when calculating achievement within QOF) compared to a CCG average of 10.5%. The practice was able to demonstrate patients had been excluded appropriately.
- The practice provided GP care to a local forensic psychiatric unit, offering a full range of GP services.
- There was proactive review and follow up of any patients with a mental health condition presenting at accident and emergency.
- Staff told us that there were 142 patients on the mental health register in 2015/16, and 89.8% had care plans reviewed that year.
- Staff had a good understanding of how to support patients with a wide range of patients with no judgements. The nursing staff told us they reviewed their appointments a day before to ensure that reasonable adjustments were made to suit the patient, for example if a room with wheelchair access was required.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published on 7 January 2016. 411 survey forms were distributed and 106 were returned. This represented a response rate of 26%.

- 68% of patients found it easy to get through to this practice by phone compared to the CCG average of 74% and national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and national average of 85%.
- 89% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and national average of 85%.
- 72% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 12 completed comment cards, all of which were positive about the care and attention received from the whole practice team. There was a common theme around patients being treated with dignity and respect and treated with compassion and kindness.

We spoke with six patients during the inspection including two members of the Patient Participation Group. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The results of the practice Friends and Family test were very positive with 93% of respondents saying they would recommend the practice to their friends and family.

# The Windmill Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to The Windmill Practice

The Windmill Practice provides primary medical services to approximately 7800 patients through a personal medical services (PMS) contract. The practice is located in very close proximity to Nottingham City Centre in purpose built premises which are shared with other local community health services. The practice is sole provider of GP services for a forensic psychiatric service and the Nottingham City Complex Alcohol Service. There is a homeless hostel located next to the practice.

The level of deprivation within the practice population is above the national average. The practice is in the first most deprived decile meaning that it has a higher proportion of people living there who are classed as deprived than most areas. Data shows number of 20 to 44 year olds registered at the practice is higher than the national average. The practice experiences a high turnover of patients due to the transient population groups in the area.

The practice team comprises seven GP partners, one salaried GP, three practice nurse prescribers, two healthcare assistants, a practice manager and the administrative/reception team. There are seven female GPs and one male GP .It is a training practice for GP registrars in training.

The practice is open between 7.30am and 6.30pm Monday to Friday. Appointment times start at 8am and the latest appointment offered at 5.50pm daily. Extended hours appointments are offered on the second Saturday of every month from 8.30am to 12.30 pm as pre-bookable appointments only with GP and nurse appointments available.

When the surgery is closed, patients are advised to dial NHS 111 and they will be put through to the out of hours service which is provided by Nottingham Emergency Medical Services.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 May 2016. During our visit we:

- Spoke with a range of staff (GPs, nurses, health care assistants, administrative staff) and spoke with patients who used the service.

# Detailed findings

- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

# Are services safe?

## Our findings

**Safe track record and learning**

The practice had an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there were recording forms available in the practice. There was a comprehensive incident management procedure in place.
- The practice adopted a blame free culture once a significant event had been reported and supported staff through an investigation into the event. All significant events were discussed at regular meetings for the various staff groups, and they were listed as a standing item on meeting agendas. Staff told us they felt comfortable with raising concerns at any time.
- Significant events were shared within the CCG if deemed appropriate. We saw evidence of completed significant event forms.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. Lessons learned were shared through discussion at routine meetings and training sessions. For example, following a number of issues raised regarding the appointments system, staff told us they had contributed to formulating new approaches.

**Overview of safety systems and processes**

The practice demonstrated they had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. There was a lead GP responsible for child and adult safeguarding and staff were aware of whom this was. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. All staff had received training relevant to their role and GPs were trained to Level 3 for safeguarding children.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Biennial infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- We reviewed five employment files for clinical and non-clinical staff. We found all of the appropriate recruitment checks had been undertaken prior to employment. Checks undertaken included proof of identification, references, qualifications, registration with the appropriate body and the appropriate checks through the Disclosure and Barring Service.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- The practice had a system in place for acting on information received from the Medicines and Healthcare Regulatory Agency (MHRA). The practice provided evidence of how they had responded to alerts in checking patients' medicines and taking actions to ensure they were safe. In addition, GPs carried out clinical audits as a result of medicine alerts.

Good

# Are services safe?

**Monitoring risks to patients**

Risks to patients and staff were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

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

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. First aid kit and accident books were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice staff demonstrated that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including the local Clinical Commissioning Group (CCG) and National Institute for Health and Care Excellence (NICE) best practice guidelines.

The practice had systems in place to keep all clinical staff up to date through clinical meetings and emails circulated by the practice manager. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We saw evidence of regular meetings with the nursing team where new guidelines were discussed as a standing item at each meeting.

The practice monitored that these guidelines were followed through risk assessments and audits, for example audits on new medicines.

GPs and nurses had specific areas of expertise, such as palliative care, diabetes, mental health and respiratory conditions, which were utilised to ensure new evidence based techniques and treatments were used to support the delivery of high quality care and acted as a resource to their colleagues. Staff told us they worked collaboratively and were supported by community specialists such as diabetes specialist nurse, district nurse and community matron and met regularly to coordinate care. In addition the nursing staff told us they attended peer review sessions arranged by the CCG where they shared learning and best practice.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed that the practice had achieved 89.6%, with an exception reporting rate of 12.1% (The exception reporting rate is the number of patients which are excluded by the practice when calculating achievement within QOF). Performance in all areas was in line with local and national averages. Data from 2014/15 showed:

- Performance for diabetes related indicators was 75.4%, which was in line with the CCG average of 79.1% but below the national average of 89.2%
- Performance for mental health related indicators was 93.2%, above the CCG average of 88.7% but in line with the national average of 92.8%
- Performance for hypertension related indicators was 100%, better than the CCG average of 97.4% and national average of 94.5%.
- Performance for palliative care indicators was 100%, in line with the CCG average of 99.2% and better than the national average of 97.8%

  The practice clinical team reviewed its performance in 2014/15 against their results in 2015/16, and used the information in planning the next year's targeted achievement. We saw evidence of detailed reflection documented with actions for the whole practice team.

  Clinical audits were undertaken within the practice.
- There had been 20 clinical audits undertaken in the last two years. Seven of these were completed audits where the improvements made were implemented and monitored. For example, the practice completed an audit to review its prescribing of a high risk medicine which is increasingly recognised as a source of harm in the long term. The audit showed that the practice had a significant number of patients with serious mental health problems who were prescribed the medicine. The patients were invited for reviews to discuss stopping the medicine and consider alternative therapies.
- Other audits which were ongoing and repeated regularly. These included diabetic retinopathy screening, missed diagnosis of diabetes, Attention Deficit Hyperactivity Disorder drug monitoring in children and adults.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. There was evidence of regular engagement with the CCG

Good

# Are services effective?

## (for example, treatment is effective)

and involvement in peer reviews. For example, the practice participated in local monitoring of their substance misuse service comparing recovery rates with other providers and sharing learning.

Staff were proactive in supporting people to live healthier lives, with a focus on early identification and prevention and treatment within primary care. The practice regularly assessed their performance in areas such as admissions and referrals. For example, between May 2014 and April 2015:

- An average of more than 300 patients per 1000 attended the Accident and Emergency (A&E) department, compared to a CCG average of 250 patients per 1000.
- An average of approximately 340 patients per 1000 outpatient referrals were made by the practice, compared to a CCG average of just under 300 patients per 1000.

The practice analysed their performance and found the reason for the increased A&E attendance was a significant number of patients attending the hospital had mental health, substance misuse and alcohol problems who often did not routinely engage with healthcare.

Vulnerable patients at risk of admission to hospital were managed proactively through the unplanned admissions register enhanced service. Under this service, all visit requests from patients on the register were triaged promptly and arrangements in place to ensure they were seen as appropriate. They were discussed at monthly multidisciplinary meetings attended by a GP, community nurse, community matron and care coordinator with actions recorded for each patient. The impact of this service was evident in the lower hospital admissions and improved emergency care for patients closer to home.

### Effective staffing

We saw staff had a range of skills, knowledge and experience to deliver effective care and treatment.

- The practice had a comprehensive induction programme for all newly appointed staff including locum doctors. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, protected learning time, clinical supervision and facilitation and support for revalidating GPs and Nurses. All staff had received an appraisal within the last 12 months.
- In addition to formal training sessions, the practice held in-house 'real life situation' training on topics such as safeguarding, to ensure that staff were confident in their knowledge and actions to take if needed.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. For example, palliative patients were managed using the Gold Standard Framework (GSF), Nottinghamshire Electronic Palliative Care Co-ordination Systems (ePaCCs) register and Special Patient Notes to ensure effective communication between agencies including the Ambulance Service and out of hours GP service. Patients with an advanced cancer diagnosis but did not require palliative care were monitored for advance planning.
- The practice made use of their close location proximity with the community teams by making referrals promptly and discussing them in person.
- The practice had a system linking them to the hospitals so that they were able view test results completed in

hospital instead of waiting to receive discharge letters. The GP out of hours service used the same clinical system as the practice therefore sharing patient information occurred seamlessly.

GPs had a buddy system for review of test results which ensured that results were viewed and acted upon on the day of receipt and patients were informed in a timely manner if the initiating GP was away from the practice. Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

**Consent to care and treatment**

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff told us they had attended local training events on Mental Capacity and were looking to carry out joint training on Deprivation of Liberties with a care home. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits. We saw evidence of completed consent forms for minor surgery procedures.

**Supporting patients to live healthier lives**

Staff were proactive in identifying patients who may be in need of extra support to live healthier lives and promote their health and wellbeing. For example:

- Patients diagnosed with complex diabetes were seen monthly by a community diabetes specialist nurse, who worked closely with practice staff to improve the outcomes for those patients.
- Weight clinics were offered in the practice and patients were given information on healthy eating and cholesterol management.
- The practice offered NHS health checks and alcohol screening to encourage healthy lifestyles and early detection of any potential long term conditions. In addition to this, the practice offered a range of services such as smoking cessation, family planning, asthma clinics and child health surveillance.

The practice's uptake for the cervical screening programme was 82.9%, which was comparable to the CCG average of 81.5% and the national average of 81.8%. The practice demonstrated how they encouraged uptake of the screening programme in all population groups by using information in different languages, opportunistic testing of eligible patients attending substance misuse clinics, and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 89.2% to 96.1% (CCG range from 91.1% to 96.3%) and five year olds from 84.5% to 94.8% (CCG range from 86.9% to 95.4%).

Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 12 completed comment cards, all of which were entirely positive about the care and attention received from the whole practice team. There was a common theme around patients being treated with dignity and respect and treated with compassion and kindness. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Feedback from patients who use the service, carers and community teams is continually positive about the way staff treat people. For example, the GPs routinely gave their personal telephone numbers to palliative care patients and their carers when they were aware that a patient is unwell especially patients coming to the end of their life. This ensured that patients were seen by their usual GP and their wishes were met during difficult times.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice satisfaction scores for nurses and receptionists were above national averages. For example:

- 87% of patients said the GP was good at listening to them compared to the CCG average of 87% and the national average of 89%.
- 86% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern which was the same as the CCG and national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

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

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Patient feedback from the comment cards we received was also positive and aligned with these views. Patients felt referrals were made appropriately and they were educated in the management of their long term conditions. We also saw that care plans were personalised.

The practice cared for patients from different backgrounds and differing lifestyles, some of whom had significant challenges with compliance with care. However, the practice actively engaged all patients.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.

Good

# Are services caring?

- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%

Staff told us that translation services were available for patients who did not have English as a first language and used sign language services for deaf patients. We saw leaflets in different languages in the reception area. The receptionists presented a chart with different languages to patients to identify which language they needed an interpreter for at Language Line.

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. For example, there was information related to carers, dementia and mental health. Information about local support groups such as carers groups, counselling services, smoking cessation and physiotherapy service was displayed.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 83 patients as carers (1.06% of the practice list). They attributed the low numbers to their population whose proportion of patients over 44 years old was significantly lower than the national average. The practice previously had a nominated carers' champion who had recently left the practice, and were looking at appointing another member of staff for this position to actively work towards identifying carers within the practice.

Staff told us they were confident in recognising people in difficulty and those who could not cope with making appointments, allowing them to present themselves at reception and then ask the GPs to fit them in where possible.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. This was in line with feedback received from a patient on the personalised bereavement support they received from the practice.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice worked to ensure its services were accessible to different population groups. For example:

- The practice offered a range of flexible appointments which included telephone appointments, nurse minor illness clinics, same day urgent and pre-bookable appointments. Minor illness clinics were offered every day where patients were seen by nurses who could prescribe medicines as appropriate.
- Extended hours appointments were offered on the second Saturday of every month from 8.30am to 12.30pm for the convenience of working patients who could not attend during normal opening hours. An additional clinic was held from 7.30am to 8am every Tuesday with a practice nurse to cater for working patients.
- Appointments with the health care assistant were available from 7.40am for working patients in need of phlebotomy services. There were 27 appointments offered each week and the practice reported these were fully utilised.
- There were longer appointments available for patients who needed them and they were encouraged to request for longer appointments if required.
- The practice were the first in Nottingham to set up shared care substance misuse clinics in 1990, and these are available on Monday afternoons, Tuesday mornings, Wednesday afternoons and Friday mornings with a GP and drugs counsellor. They saw approximately 150 patients during these clinics, the highest number in Nottingham practices offering this service.
- A hepatitis C nurse was available alongside the substance misuse clinics, offering advice, testing, diagnosis and treatment. This was an unpaid service offered by the practice.
- The practice hosted a physiotherapy clinic twice a week on Wednesday mornings and Friday afternoons. Patients were encouraged to self-refer to this service. Practice supplied evidence indicated this was a popular service with appointments uptake ranging from 16 to 48 a month, and approximately 500 patients having used it between March 2015 and June 2016.
- The GPs provided medical care to patients who were resident a local alcohol detox unit. In addition, they provided GP specialist services at two complex alcohol clinics every week provided in the community.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those with medical problems that required same day consultation with an on call doctor. Drop in baby clinics were also offered on Thursday afternoons with a GP and practice nurse available. A maternity waiting list was created as soon as pregnancy was confirmed. The practice tracked the patients on the list so that no one missed the relevant reviews.
- The practice used text reminders for appointments with the option to cancel by text.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available when required.
- New patients were given an information pack which included a guide to local services, minor illness management at home, managing medicines and local pharmacy information.
- The practice accepted temporary residents to register and participated in the out of area registrations scheme to cater for patients from the traveller community and homeless patients.
- Patients with diabetes and Alzheimer's were encouraged to attend courses educating them on how to manage their conditions and actively take ownership of their care.

**Access to the service**

The practice was open between 7.30am and 6.30pm Monday to Friday. Appointment times started at 8am and the latest appointment offered at 5.50pm daily. Extended hours appointments were offered on the second Saturday of every month from 8.30am to 12.30pm as pre-bookable appointments only with GP and nurse appointments available.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

In addition to pre-bookable appointments that could be booked up five days in advance for the GPs and three weeks in advance for the nurses. Urgent appointments were also available for people who needed them. Patients could access appointments online and request repeat prescriptions using the electronic prescriptions service.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 75% of patients were satisfied with the practice's opening hours in line with the CCG average of 77% and the national average of 75%.
- 68% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 73%.
- 90% of patients said they were able to get an appointment to see or speak to someone the last time they tried, compared to the CCG average of 83% and the national average of 85%.

The practice was aware of these results and looking to improve access. For example, they had plans to put additional telephone lines for appointments and were recruiting a receptionist to fill a vacant post. People told us on the day of the inspection that they were able to get appointments when they needed them. The practice had identified that compliance with appointments was difficult for vulnerable people, so they encouraged these patients to present to reception whenever they felt the need for medical care and an appointment was offered to them on the day. In addition, prescription requests were fulfilled within 24 hours to ensure that patients whose lifestyle was often less organised did not run out of their medicines.

**Listening and learning from concerns and complaints**

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the reception area.

We looked at 14 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Apologies were given to people making complaints where appropriate. Lessons were learnt from individual concerns and complaints and also from analysis of trends, and actions were taken to as a result to improve the quality of care. For example, complaints were discussed at practice team meetings so that any learning was shared and changes to policies and procedures are implemented as a practice team. Feedback from the Friends and Family test was reviewed at the weekly practice team meetings.

# Are services well-led?

Outstanding ☆

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

## Our findings

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement centred on providing accessible healthcare for all patients. There was a clear focus on breaking down barriers, stigma and prejudice to provide equitable health services for all patients. Staff were involved in agreeing the mission statement and understood the values especially teamwork. They demonstrated an understanding of their demographic by configuring their services to support their patients, particularly those in vulnerable groups.
- Staff told us they did not feel that a hierarchical structure existed between them and the GPs.
- The practice was aware of the limitations of their current premises given the potential growth of the practice and population following proposed housing developments in the area. They worked with their CCG on developing an estates strategy.
- Regular management meetings were held to discuss succession planning.

**Governance arrangements**

The practice had an effective governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. All partners had clear responsibilities in both clinical and non-clinical areas which all the staff were aware of.
- Practice specific policies were implemented and were available to all staff. We saw that there were various meetings held between the different staff groups in addition to the whole practice meetings where policies and changes were discussed.
- There was a comprehensive understanding of the performance of the practice in respect of QOF achievement, access to appointments and patient satisfaction. There was evidence of a high level of reflection on performance as a practice team with minutes taken of all meetings to ensure absent staff had access to all discussions. Staff contributed to action plans to improve performance. For example, when patients attended substance misuse clinics, and their cervical smears were due, staff arranged joint appointments to ensure all tests were carried out in one visit.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were systems in place for identifying, recording and managing risks, issues and implementing mitigating actions.

**Leadership and culture**

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. For example,

- We saw that GPs had special interests and additional qualifications in a range of areas such as alcohol and substance misuse problems, domestic violence and child safeguarding. These skills were used in providing care to patients within the practice as well as the wider CCG and Nottinghamshire area.
- The GPs used their expertise and experience to offer training events and seminars within the local health community and nationally on learning disabilities, managing health of asylum seekers, and management of alcohol problems in primary care, blood borne viruses, substance misuse and domestic violence.
- The GPs sat on various committees where they were able to influence decisions on health care services for patients locally and nationally, for example Better Health multiagency committee, local mental health trust committee, Nottingham Multiagency Migrant Health Forum and the national Primary Care Child Safeguarding Forum.

Staff told us the partners and practice manager were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty. Constructive challenge from

# Are services well-led?

Outstanding ☆

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

patients, carers and staff were encouraged and complaints were acted on effectively. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.
- The practice reviewed all complaints for emerging themes so that lessons could be learned to avoid recurrence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings between the staff groups and as a practice, which was evident from the minutes of meetings held.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The partners looked at staffing issues and actively provided cover from within the practice during leave of absence, reducing the need for employing locum doctors.
- There was positive feedback from registrars who have trained at the practice that the partners provided an excellent level of mentorship for their trainees.

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

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

- The practice had gathered feedback from patients through the national patient survey and carried out their own patient surveys on a regular basis. They reviewed the results at team meetings and discussed ways to continually improve the results and commend the team for positive results.
- The practice had formed a patient participation group (PPG) at the end of 2015 which had met twice since its inception. Feedback from members of the PPG demonstrated that the group was keen to drive improvements in the practice and engage other patients who use the service. Recruitment of members was still in progress and forms were available in the reception area informing patients how to join the PPG.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff were asked to provide feedback for the practice manager's appraisal. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and felt engaged to improve how the practice was run.

**Continuous improvement**

- There was a focus on continuous learning and improvement at all levels within the practice and the wider local health community. The GPs provided unpaid supervision to colleagues training to become non-medical prescribers within and outside the practice. These included a midwife, hepatitis C nurse, community matron and a local pharmacist. They also offered work experience to sixth form students interested in a medical career.
- The practice team were forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, one of the GPs suggested a pilot scheme to raise awareness of prostate cancer for men of African Caribbean ethnic background due to their increased risk and mortality. The pilot scheme was successful and is now a commissioned service recognised nationally as good practice.
- The practice involvement in a clinical trial offering hepatitis C treatment during their substance misuse clinics pioneered a primary care based service which is now commissioned locally to all practices offering substance misuse care.
- The practice proposed a community epilepsy specialist nurse service for patients who did not engage with

# Are services well-led?

Outstanding ☆

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

health care services. The nurse provides one to one contact with patients who do not attend hospital clinics, encouraging them to attend their reviews and offer expert advice. The service was successfully rolled out to most practices in Nottingham.

- Other services that have been driven by the practice and are now offered throughout Nottingham practices include urgent GP referrals to the Welfare Rights Service, a patient education college for mental health needs and a carers support worker who offers support to carers of elderly patients who have been discharged from hospital.