# Hickings Lane Medical Centre

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

We carried out an announced comprehensive inspection at Hickings Lane Medical Centre on 25 July 2016. Overall the practice is rated as outstanding.

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. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunities for learning were maximised.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. There was a very supportive approach to staff development to ensure they had appropriate skills and experience. The practice used clinical audit to improve patient care and drive quality improvement within the practice.
- The practice participated in the structured apprentice programme for young adults aspiring to work in primary care.
- The practice had systems in place to seek consent to summary care records from patients reaching their sixteenth birthday.
- The practice worked effectively with the wider multi-disciplinary team to plan and deliver integrated care that was responsive to the needs of patients.
- The practice used proactive methods to improve patient outcomes, working with other local providers to share best practice. This included teledermatology and tele-consultations with hospital consultants.
- The practice proactively reached out to the community and worked constructively with other organisations to promote patient education and a healthy lifestyle.
- Feedback from stakeholders and patients about their care, and interactions with all practice staff, was

# Summary of findings

consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice offered extended opening hours between 7.30am and 7pm Monday to Friday, with the exception of Thursday when the practice closed at 6.30pm. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed with stakeholders and discussed with staff.
- There was a strong and proactive leadership structure within the practice, and staff felt well-supported by management.
- The leadership drove continuous learning and improvement at all levels, and staff were accountable for delivering change.

We saw several areas of outstanding practice:

The emotional and social needs for children and young people were seen as important as their physical needs. For example:

- As part of a community project, one of the GP partners had worked with local organisations, young people and children to promote anti-bullying. This included a theatrical production aimed to empower young people to explore anti-bullying issues and seek support when needed.
- The practice team championed the delivery of good quality care and a flexible service to young people residing in secure children's home. Ofsted had positively recognised the input of the GPs and practice nurses (and other agencies) in the support provided to the children.
- The practice offered a range of extra services which provided care closer to patients' homes and reduced referrals and / or burden on hospital services. For example, ultrasound scanning for orthopaedic, musculosketal and dermatology conditions and detection of breech presentations in pregnant women. In addition, the daily extended hours enabled improved access to services for patients.

**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 effective system in place for reporting, recording and investigating significant events. Learning was based on a thorough analysis and shared with staff and external organisations to support wider improvement.
- The practice had effective systems in place to ensure they safeguarded vulnerable adults and children from abuse. This included collaborative working with the health visitor, midwife and social workers.
- The arrangements for managing medicines and vaccines kept patients safe. The practice employed a pharmacist to support the clinicians, and as a result positive outcomes were achieved for patients.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe. This included the management of infection control practices and the risks related to the premises, environment and equipment.
- Staff had received appropriate pre-employment checks and sufficient staff with the right? appropriate skills and experience were in place to meet patients' needs.
- The practice had plans in place for dealing with emergencies and staff we spoke with understood their individual roles. This included providing basic life support in a medical emergency, and having a business continuity plan in place for major incidents.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

- The practice had systems in place to ensure all clinicians were kept 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 staff used these guidelines to influence and improve practice and patient outcomes.
- The practice used evidence-based procedures and technologies to support the delivery of high-quality care. This included use of ultrasound scans to detect breech presentation in later pregnancy and screening of abdominal aortic aneurysm.

# Summary of findings

- Published data showed the practice was performing highly when compared to other practices nationally.
- The practice had an embedded programme in place for undertaking clinical audits with evidence of quality improvement. The practice had achieved three awards for clinical audits related to specific medicines and consent.
- Staff had the skills, knowledge and experience to carry out their roles effectively. They were supported to deliver effective care and treatment through supervision, appraisal and personal development plans.
- Multi-disciplinary working with other health care professionals promoted the provision of integrated care for patients with complex health needs, and / or living in vulnerable circumstances. Feedback from external stakeholders was wholly positive.
- Staff were proactive in supporting residents within the local community to live healthier lives. This included facilitating healthy lifestyle events for different population groups, and focusing on patient education and empowerment, prevention of ill-health and supporting people to improve their health and wellbeing.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

- Feedback from patients about their care and treatment was consistently positive. Patients told us they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Patients also gave specific examples of when staff addressing the risk of their health condition deteriorating and to ensure their wellbeing.
- People's emotional and social needs were seen as important as their physical needs. For example, one of the GP partners had a passion to minimise children and young people being bullied and as a result was proactive in facilitating theatre shows related to the anti-bullying campaign. Over 200 patients had responded to the Age UK 'Fit for the Future' project in 2015. This project was aimed at improving the mental health and physical wellbeing of patients aged 65 and over. A congratulations card was also sent to mothers when they had a new baby.
- Views of external stakeholders were very positive in respect of the high level of care provided by the practice team and was aligned with our observations.
- A caring and person centred attitude was demonstrated by all staff we spoke to during the inspection.

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- Data from the national GP patient survey showed patients rated the practice in line with the local and national averages for several aspects of care. For example, 85% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the local average of 86% and the national average of 85%.

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

**Outstanding** ☆

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and the local community in planning how services were provided, to ensure that they meet patients' needs. For example, the practice was scheduled to merge with another local practice by April 2017, which would increase service provision and accommodate the training of medical students and doctors.
- The practice offered extra services which provided care closer to patients' homes and helped reduce the pressures on hospital services. For example, the practice had purchased a dermatoscope which was used to examine patients with pigmented skin lesions, and images were sent to hospital dermatology consultants.
- The practice had initiated positive service improvements for its patients that were over and above its contractual obligations.
- The practice offered extended opening hours between 7.30am and 7pm Monday to Friday with the exception of Thursday when the practice closed at 6.30pm.
- Patients we spoke to and comment cards received were very positive about people's experience in obtaining both urgent and routine appointments. This feedback was aligned with most of the national GP survey results.
- The practice had good facilities and improvements were being made to the premises to ensure they were suitable for all patients to 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.

**Are services well-led?**

**Outstanding** ☆

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

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- The practice had a clear vision with 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.
- There was a clear leadership structure and staff felt supported by management.
- High standards were promoted and owned by all practice staff and there was strong team working across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. This included policies and procedures, arrangements to address risks and monitor the service provision.
- There was a high level of satisfaction and constructive engagement amongst the staff team.
- The practice had a very engaged patient participation group which influenced practice and community developments.
- The leadership drove continuous learning and improvement at all levels, and staff were accountable for delivering change.
- The GP partners undertook lead roles outside of the practice which helped enhance the quality of care for patients and influenced decisions about service provision within the local area.

# 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 good for the care of older people.

- The practice had facilitated a community outreach event in 2014 aimed at people aged over 65. About 60 people participated in the event and various organisations attended including the citizens advice bureau and a community based dietician.
- Over 200 patients over the age of 65 had responded to the Age UK 'Fit for the Future' project in 2015. Some of the support offered to patients included claiming for attendance allowance, signposting to social groups, the community transport scheme and occupational services.
- Data reviewed showed clinical outcomes for conditions commonly found in older people were above local and national averages. This included osteoporosis and rheumatoid arthritis.
- Monthly multi-disciplinary care meetings were held to ensure integrated care for older people with complex health care needs, and those who were frail and elderly. This allowed patients to be cared for in the community and avoid unnecessary hospital admission.
- Longer appointment times and home visits were available for those unable to attend the surgery; and every patient over the age of 75 years had a named GP.
- Influenza and shingles vaccinations were offered to older patients in accordance with national guidance.

### People with long term conditions

Good

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

- The practice had facilitated a community healthy lifestyle outreach event in July 2014, which provided information and support for people who had coeliac disease, lactose intolerance and those wanting advice regarding weight management. Following this event, the practice nurse and community dietician held a six week weight management course for the attendees including non-registered patients.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice team monitored hospital admissions and discharges, and telephoned high-risk patients to assess if any additional help was required.

# Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with the local community health teams to deliver a multidisciplinary package of care. This included specialist nurses for heart failure, diabetes and palliative care.
- Joint clinics were undertaken with a diabetic specialist nurse on a monthly basis to facilitate the management of patients with complex needs. This enhanced the skills of the practice nurse and enabled them to initiate insulin at the practice.
- Uptake rate of vaccinations for long term conditions including flu and pneumococcal vaccinations were relatively high when compared with the local average.
- Longer appointments and home visits were available when needed.

**Families, children and young people**

**Outstanding** ☆

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

- The GPs and practice nurse undertook regular visits to a secure unit for young people aged between 10 and 17 years. The service offered by the GPs and practice nurse was recognised in the care homes' Ofsted annual report, which rated the provider as outstanding.
- Pregnant mothers were offered an ultrasound scan in order to help spot breech babies before they were born. This enabled the obstetrician and midwife to discuss with the mother the best and safest form of delivery. Breech presentations occur when the baby is lying feet first with their bottom downwards. Expectant mothers could access a weekly ante-natal clinic held by the community midwife.
- Childhood development checks and vaccinations were jointly carried out by the GP and practice nurse in line with national guidelines. This included neonatal checks, six week post-natal checks for new mothers and eight week baby checks.
- The uptake rates for childhood immunisations were high and above the local averages. For example, published data showed vaccination rates for children under two years old ranged from 97% to 100% compared to the local average ranging from 96% to 97.5%.
- Records reviewed demonstrated positive examples of joint working with midwives, health visitors, school nurses and social worker. This included six-weekly safeguarding meetings to

discuss children in need, on protection plans, at risk of deteriorating health needs and their families. All staff had received relevant training in safeguarding children and vulnerable adults.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and this included same day appointments for children aged two and under.
- The premises were suitable for children and baby changing facilities were available.
- The practice staff and the patient participation had facilitated a community outreach event in March 2014 aimed at families and young people. A total of 21 adults and 18 children attended. The activities included a mother and baby yoga session, information relating to Sure Start, support services for children with disabilities and breast feeding.

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

Outstanding ☆

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

The needs of patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

- The practice provided extended opening hours and appointments five days per week and this included appointments to see the GP, practice nurse and healthcare assistant from 7:30am. Feedback from most patients was consistently positive about their experience in obtaining an appointment quickly and at a convenient time for them.
- A text reminder service was used to remind patients of their pre-booked appointment 24 to 48 hours in advance to help reduce non-attendance for appointments.
- Telephone consultations were available each day for those patients who had difficulty attending the practice due to work commitments for example.
- The practice promoted the use of online services to book and cancel GP appointments, order repeat prescriptions and review a summary of their medical records.
- Students could register as a temporary resident outside of the university term time.
- A full range of contraceptive services including a coil fitting service and contraceptive implants was offered.

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- Both GPs had additional qualifications in sports medicine and dermatology which was beneficial for patients, in that diagnostic and screening procedures were undertaken within the practice and data reviewed showed patients had quick access to treatment and care where required.
- The practice promoted health screening programmes that reflected the needs for this age group. This included travel vaccinations and screening for prostate cancer and abdominal aortic aneurysm. Uptake rates for cervical screening for women between the ages of 25 and 64 and NHS health checks for patients aged 40 to 74 were above the local averages.

**People whose circumstances may make them vulnerable**

Good

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

- The practice held a register of patients living in vulnerable circumstances including patients with a learning disability. All of the 24 patients with a learning disability had received an annual review in the last 12 months, and the practice staff had completed learning disabilities awareness training.
- The practice offered a flexible service to patients who needed to attend appointments with a carer. Appointments were arranged outside of normal clinical times if required.
- The practice team was aware of the new guidelines regarding accessible information standards, and as a result proactively identified patients who required additional support at the point of registration. These patients were then set up with an alert on the computer system to ensure they were easily identifiable to all staff.
- The practice provided relevant information and support for carers and patients receiving end of life care. Patients were kept under close review by the practice team in liaison with the wider multi-disciplinary team.
- All staff had received safeguarding training relevant to their roles, including domestic violence, consent and the Mental Capacity Act 2005. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Patients were able to access an interpreter for pre-booked appointments, a chaperone if needed, weekly dosettes, a wheelchair within the premises and information in large print.

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

Good

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

- The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. This included advance care planning for patients with dementia and collaborative working with the local mental health team, to ensure patients experiencing acute difficulties or a crisis, received urgent intervention to manage their condition.
- Same day appointments and home visits were offered to patients if needed.
- A system was in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. This included referring patients to services providing psychological and talking therapies, providing information on various support groups and voluntary organisations, as well as liaising with the community geriatrician about their care.
- Arrangements were in place to ensure patients taking high risk medicines requiring regular and essential blood monitoring took place in a timely way.

Published data showed approximately:

- 93% of patients on the practice's mental health register had received an annual health check in 2014/15. This was in line with the local average and 5% above the England average.
- 78% of people diagnosed with dementia had had their care reviewed in a face to face meeting during 2014/15. This was 8% below the local average and 6% below the national average.

# Summary of findings

## What people who use the service say

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 74 comment cards which were all positive about the high standards of care received. Patients commented they were treated with dignity and upmost respect and staff were described as being friendly, compassionate and accommodated their needs.

We spoke with four patients / members of the patient participation group. All patients said they were satisfied with the care they had received and thought staff were approachable, committed and caring.

We reviewed the national patient survey results published in July 2016. A total of 222 survey forms were sent out and 116 patients responded. This represented a 52% completion rate and 2.4% of the practice's patient list. Most of the results showed the practice was performing in line with or marginally below the local and national averages. For example:

- 95% of patients said the last appointment they got was convenient compared to the CCG average of 96% and national average of 92%.
- 91% of patients described the overall experience of this GP practice as good compared to the CCG average of 90% and national average of 85%.
- 88% 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 82% and national average of 78%.
- 84% of patients found it easy to get through to this practice by phone compared to the CCG average of 87% and national average of 73%.

The practice team and patient participation group (PPG) were aware of the lower satisfaction rates, and improvement work had been undertaken and was monitored to further improve patients' experience of accessing the service.

## Areas for improvement

## Outstanding practice

The emotional and social needs for children and young people were seen as important as their physical needs. For example:

- As part of a community project, one of the GP partners had worked with local organisations, young people and children to promote anti-bullying. This included a theatrical production aimed to empower young people to explore anti-bullying issues and seek support when needed.
- The practice team championed the delivery of good quality care and a flexible service to young people residing in secure children's home. Ofsted had positively recognised the input of the GPs and practice nurses (and other agencies) in the support provided to the children.
- The practice offered a range of extra services which provided care closer to patients' homes and reduced referrals and / or burden on hospital services. For example, ultrasound scanning for orthopaedic, musculosketal and dermatology conditions and detection of breech presentations in pregnant women. In addition, the daily extended hours enabled improved access to services for patients.

# Hickings Lane Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

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

## Background to Hickings Lane Medical Centre

Hickings Lane Medical Practice provides primary medical services to about 4,800 patients. The practice is located in the second most deprived area of Broxtowe (a borough of about 106,000 people). The practice has invested heavily in a major building extension (addition of five consulting rooms and a treatment room) which is due to be completed in September 2016. This will enable the practice team to better cater for the future health needs of their growing population.

The clinical team comprises two GP partners (male and female), a locum GP (female), two practice nurses (female) and two health care assistants (female). The clinicians are supported by an administration team comprising of a full-time practice manager, a data administrator/ receptionist, senior receptionist, two receptionists and an apprentice receptionist.

Hickings Lane Medical Centre is a GP training practice offering placements for medical students from the University of Nottingham medical school. The practice currently has first, second, fourth and fifth year medical students.

The practice opens from 7.30am to 7pm Monday to Friday with the exception of Thursdays when the practice closes at 6.30pm. The telephone lines are switched over to the out of hours service between 12.30pm and 4.30pm on Thursday but the surgery remains open. Appointments are available from 8.30am to 12pm each morning and 2pm to 6pm in the evening. Extended hours for appointments with the GP, nurse and health care assistant are provided from 7.30am to 8am daily.

Same day appointments are released at 8am for a morning appointment and 2pm for an afternoon appointment. Routine appointments could be forward booked up to three months in advance.

The practice has opted out of providing out-of-hours services to its own patients. This service is provided by Nottingham Emergency Medical Service (NEMS).

## 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

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?

# Detailed findings

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 July 2016. During our visit we:

- Spoke with a range of staff (GPs, practice nurse, practice manager, reception staff and an apprentice).
- Spoke with allied professionals – Care coordination administrator, end of life palliative nurse, diabetes specialist nurses, health visitor and the CCG medicines management team.
- Spoke with four members of the patient participation group who used the service.
- Observed how patients were being cared for and interactions with staff.
- Reviewed 74 comment cards where patients shared their views and experiences of the service.
- Reviewed a range of records held by the practice and a sample of the treatment records of patients to corroborate our evidence.

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

All of the staff we spoke with understood their responsibilities to raise safety incidents, concerns and near misses; as well as to report them internally and externally where appropriate. There was a focus on openness, transparency and learning when things went wrong. For example:

- Staff told us they would inform the practice manager or one of the GP partners of any significant events and this would be documented on a recording form.
- The incident forms were kept in the significant event file which was accessible to all staff for review. The form included information on why the incident happened, lessons learned and action taken and / or changes made to improve safety within the practice.
- A total of nine significant events had been recorded and discussed by the practice team over the preceding 12 month period. The review and analysis of significant events was comprehensive and embedded into the practice meeting agenda.
- As well as discussing significant events with staff, they were discussed with other professionals outside the practice so that ideas for improvement could be shared. This included sharing successes and significant events with colleagues at protected learning events organised by the clinical commissioning group (CCG).
- When things went wrong with care and treatment, patients received a written apology and / or were told about any actions to improve processes to prevent the same thing happening again.

The practice had an effective system in place for receiving and acting on medicine alerts, medical devices alerts and other patient safety alerts. One of the clinicians took a lead role in disseminating the alerts to the practice team. When concerns were raised about specific medicines, patient searches were undertaken to identify patients that may be affected. Appropriate action including the review of prescribed medicines, was then taken by clinicians to ensure patients were safe.

### Overview of safety systems and processes

The arrangements in place to safeguard children and vulnerable adults from abuse had been strengthened following a serious case review involving a child that was formerly registered with the practice. A serious case review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. Improvement areas had been identified and implemented.

- Safeguarding meetings were held every six weeks to discuss children and families at risk of abuse or deteriorating health needs. In attendance were GPs, the practice nurse, practice manager, midwife, health visitor and school nurse. The minutes of the meeting were directly entered onto the patient record as they were discussed.
- Systems were in place to identify risk factors relating to vulnerable adults, children subject to child protection plans, in care of the local authority and in need of additional support.
- Written feedback from the designated nurse safeguarding children stated that she observed the multi-professional safeguarding meeting and saw an excellent example of multi-disciplinary information sharing, and care planning around children and families at risk. Good practice identified included “a think family” approach which ensured the needs of parents were considered alongside the needs of children.
- Positive feedback was also received from the health visitor and this included shared access to records, support for women with pre-natal depression and follow-up systems in place for children who did not attend medical appointments, or were admitted to A&E.
- Staff had access to policies and procedures to guide them in identifying and preventing abuse from happening. This included information on whom to contact for further guidance if they had concerns about a patient’s welfare.
- Staff we spoke with demonstrated they understood their responsibilities to safeguard patients and all had received training relevant to their role. All non-clinical staff had received training in domestic violence and child safeguarding (level one).
- The clinicians were all trained to level three safeguarding children. Records reviewed showed they maintained oversight of all safeguarding referrals made to the multi-agency safeguarding hub team and provided reports for external agencies.

Good

# Are services safe?

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe.

- There were notices in the waiting room advising patients that chaperones were available if required. The offer and use of a chaperone during intimate examinations for example, was recorded in the patient record. 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 visibly 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. The practice had infection control related policies in place and staff had received up to date training. Annual infection control audits were undertaken with the most recent audit completed in May 2016. We saw that appropriate action had been taken to address identified improvements. For example, records reviewed showed meetings had taken place with the cleaner to address identified concerns, and the cleaning schedules had been updated. Further improvements were scheduled to take place following the extension and refurbishment of the premises.

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).

- The practice carried out regular medicines audits with the support of the local CCG medicines management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The clinicians and named pharmacist had focused on four areas that promoted safer prescribing and reduction in medicine wastage. This included management of neuropathic pain (the pharmacist attended a pain management session as a result), review of all medicines for patients discharged from hospital and review of patients on more than six medicines (polypharmacy).
- The practice team also recognised that some patients received medicines directly from hospital clinics, which could have interactions with medicines prescribed by the GPs. Following the appointment of the practice pharmacist, a system was introduced to record medicines prescribed by hospital professionals allowing interactions to be checked against acute medicines prescribed by the GPs.
- Blank prescription printer stationery (this includes pads and computer paper) was held securely and logged on arrival. Processes were in place to ensure the safe handling of repeat prescriptions. For example, all prescriptions collected by local pharmacies were documented and signed for to provide an audit trail of prescriptions leaving the surgery.
- The practice had a dedicated prescription telephone line to enable patients to order prescriptions over the phone if they struggled to get into the surgery due to work commitments for example. Any prescription including a controlled drug was signed for by the collector and the slip was then scanned into the patient record.
- Effective recall systems were in place for ensuring patients on high risk medicines received regular monitoring of their health needs and essential blood tests were undertaken.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and appropriate DBS checks.

### Monitoring risks to patients

A proactive approach to anticipating and managing risks to patients and people who accessed the service was embedded and recognised as the responsibility of all staff. Risks to patients were assessed, monitored and well managed.

- There was a health and safety policy in place and lead staff members had attended a health and safety risk assessment course in April 2016. This had resulted in an improved system for reviewing, rating and monitoring risk assessments to ensure they were up to date and prioritised appropriately.

Good

# Are services safe?

- The practice had a variety of risk assessments in place to monitor the safety of the environment and work related activities. This included control of substances hazardous to health and legionella (a term for a particular bacterium which can contaminate water systems in buildings).
- The practice had an up to date fire risk assessment in place and fire extinguishers were regularly serviced. Fire drills had been carried out in January and July 2016 and improvements had been made as a result, to ensure the safe evacuation of people using and accessing the service.
- Suitable arrangements were in place to ensure the safety and suitability of equipment. For example, clinical equipment was calibrated to ensure it was working properly and portable appliance testing had been undertaken for electrical equipment to ensure it was safe to use.
- Risks to safety from service developments, anticipated changes in demand and disruption were assessed, planned for and managed effectively. For example, the practice had commenced a substantial extension to the premises. At the time of our inspection, 60% of the work had been completed and relevant risk assessments were in place to ensure the safety of people accessing the service.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. For example, a rota system was in place for all the different staffing groups to ensure enough staff were on duty. Any staff absences were responded to quickly. We were provided with examples of how the team worked flexibly to ensure adequate cover was available at all times and adjustments made to clinics due to patient demand.

### 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 had up to date training in cardio pulmonary resuscitation and / or basic life support.
- The practice kept an emergency trolley which comprised of a defibrillator, oxygen with adult and child masks, an ambu bag (a resuscitator bag used to assist ventilation) and emergency medicines. The practice nurse undertook weekly checks of all emergency equipment and medicines.
- All the medicines we checked were in date, stored securely and all staff knew of their location
- A list of medicines considered appropriate for an urban or suburban doctor to carry in their bags was created and all bags had been reviewed and stocked with recommended medicines.
- A first aid kit and accident book were also available.
- The practice had a comprehensive business continuity plan in place for major incidents. The plan included emergency contact numbers for staff and identified a 'buddy' practice the staff would work with in such circumstances. This plan was reviewed periodically and copies were kept off the premises.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice team assessed patient's needs and delivered care in line with relevant and current evidence based guidance and standards. This included the National Institute for Health and Care Excellence (NICE) best practice guidelines and local prescribing guidelines.

- The practice had a lead GP who reviewed the NICE guidelines and cascaded the updated information to clinical staff ensuring changes were made if necessary.
- Staff then used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and review of patient records.
- Patients we spoke with and comments cards received confirmed that staff undertook a holistic approach to assessing, planning and delivering their care and treatment. For example, most of the 74 comment cards we received gave specific examples to confirm patients had received a comprehensive assessment of their individual needs, which included their physical health and mental wellbeing. The clinical outcomes were discussed with them and care and treatment was regularly reviewed.
- Risk profiling was also used to ensure patients had their health needs assessed and that care was planned and delivered proactively. This included patients at risk of hospital admission, patients at risk of developing a long-term condition and patients likely to die within the next 12 months and require end of life care.
- Practice supplied data for 2014/15 showed 22 out of 24 patients had undertaken AAA screening (92%) compared to a clinical commissioning group (CCG) average of 83.3% and national average of 80%.
- One of the GP partners had a special interest in ultrasound scanning and had received additional training and mentoring to provide this specialist service from the practice. For example, the GP undertook ultrasound scans to detect breech presentation in later pregnancy. Breech presentations occur when the baby is lying feet first with their bottom downwards. The GP partner explained the protocols in place to ensure risks to expectant mothers were safely managed and clinical audits were used to review patient outcomes. If a breech delivery was diagnosed, the GP would refer the expectant mother directly to the relevant specialist / obstetrician for further care and discussions on the safest form of delivery.

### 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 practice has consistently maintained a track record of high QOF performance over the last nine years with achievements above 93%. The most recent published results (2014/15) showed the practice had achieved 97.5% of the total number of points available. This was the same as the CCG average and was above the national average of 95%.

The overall exception reporting rate was 9% which was in line with the CCG and national averages. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

The published data showed:

- Performance for diabetes related indicators was 90.3% and this was marginally below the CCG average of 95.8% and above the national average of 89.2%. The overall exception reporting rate for diabetes was 11% which was in line with the CCG and national averages.
- Performance for indicators related to hypertension was 100% and this was marginally above the CCG average of 99.4% and national averages of 97.8%. The overall exception reporting rate for hypertension was 4% compared to the CCG average of 3% and national average of 4%.
- Performance for dementia health related indicators was 91.2% which was below the CCG average of 99% and national average of 94.5%. The exception reporting rate for dementia related indicators was 9% which was in line with the CCG average of 7% and the national average of 8%.

Good

# Are services effective?

## (for example, treatment is effective)

- Performance for mental health related indicators was 96.7% which was in line with the CCG average of 98.4% and national average of 92.8%. The exception reporting rate for mental health related indicators was 12% which was above the CCG and the national averages of 11%.

The practice was aware of areas for improvement and had implemented strategies to support this resulting in improved QOF achievements. For example, practice supplied data for 2015/16 showed performance for diabetes indicators had increased to 93% and dementia related indicators had increased to 100%. This data was yet to be verified and published.

There was evidence of quality improvement including a programme of clinical audit.

- We were shown 10 clinical audits completed in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- For example, the purpose of one audit was to determine the number of patients who had been suitably assessed for anticoagulation using a risk stratification tool which calculates the stroke risk for patients with atrial fibrillation (irregular heartbeat). The second audit cycle demonstrated a 17% increase in the number of eligible patients assessed and all of them had received appropriate care and treatment.
- The practice worked closely with the CCG medicines team to ensure prescribing was cost effective and adhered to local guidance. Records reviewed showed significant improvements had been made within the last 12 months to ensure antibiotic prescribing was in line with the local average.
- Opportunities to participate in benchmarking, peer review and accreditation were proactively pursued.For example, in collaboration with another local practice, the GPs regularly reviewed their secondary care referral rates and hospital admissions to drive improvement and enhance best practice.

### Effective staffing

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care.

- The practice participated in the structured apprentice programme for young adults aspiring to work in primary care. The apprentice we spoke to commented positively about the induction and ongoing training they had received.
- The practice had an induction programme for all newly appointed staff and medical students.
- Staff had access to ongoing training (via e-learning modules and in-house training) to meet their learning needs and to cover the scope of their work. This included training on information governance, customer care, dementia and disability awareness.
- An action plan was in place to ensure all staff had completed refresher training and courses considered mandatory by the provider by 30 September 2016.
- The practice ensured role-specific training with updates was undertaken for relevant staff For example, clinical staff reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- The practice team had protected learning time on one afternoon each month and this included attending training events organised by their CCG.
- All staff employed for over a year had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to identify their strengths and areas of development, as well additional training needs to ensure their learning objectives were met.
- Clinical staff met together at the end of their clinics informally and this offered an opportunity to share information, and to resolve any issues that had arisen that day. In addition, GPs and nurses attended weekly clinical meetings and engaged in activities to monitor and improve patient outcomes.
- Staff were proactively supported to acquire new skills and share best practice. For example, one of the GP partners had shadowed a spinal consultant for a month and learned to undertake nerve root and feet injections for patients under 15.

### Coordinating patient care and information sharing

The systems to manage and share information were coordinated effectively and supported the delivery of integrated care for patients. For example:

Good

# Are services effective?

## (for example, treatment is effective)

- All paper and electronic records relating to people's care was well managed. Staff could easily access the information they needed to assess, plan and deliver care to people in a timely way. This included medical records, care / treatment plans, investigation and test results; as well as information shared between the GP out-of-hours service and secondary care services.
- When people were referred, discharged or transitioned to a new service, information that was needed to deliver their on-going care was appropriately shared.

The practice team worked collaboratively with other health and social care professionals to assess the range and complexity of patients' needs, and plan their ongoing care and treatment. This included hospital consultants and professionals from the local GP owned provider organisation primary integrated community services Ltd (PICS). We spoke with two community specialist nurses and the care coordinator employed by PICS. They confirmed effective multi-disciplinary and case management took place resulting in improved care and outcomes for patients. This included patients suffering from long term conditions such as diabetes, atrial fibrillation, chronic pain and chronic obstructive pulmonary disease (a collection of lung diseases). The use of the community services had resulted in a reduction in secondary care referrals.

Monthly multi-disciplinary meetings were held between practice staff and other professionals including district nurses and the community matron. The meetings prioritised the care and treatment of patients receiving end of life care, patients living in care homes, patients with complex mental health needs and / or at high risk of hospital admission for example. Care plans were routinely reviewed and updated for patients.

### Consent to care and treatment

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

- Consent practices and records were actively reviewed to improve the involvement of patients in making decisions about their care and treatment. For example, one of the GP partners in conjunction with a medical student produced a bespoke consent form for musculoskeletal steroid injections to aid informed consent by ensuring patients were fully informed of the risks, benefits and alternative options discussed. The form was trialled on patients attending the practice's community hand clinic, and eventually formed part of the student's project which was awarded second prize. The learning derived from developing this form was shared widely with other stakeholders; for example, via lectures at the Pulvertaft Hand Clinic and at protected learning events organised by the CCG. The use of the consent form had been audited and contributed to a 100% steroid injection consent rate within the practice.
- The practice had systems in place to seek consent to summary care records from patients reaching their sixteenth birthday. A standard letter was sent to patients who had reached the age for this particular initiative.
- Three of the comment cards we received confirmed consent was sought before a medical student observed their individual consultation as part of their learning.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. They had received relevant training in consent and / or the Mental Capacity Act 2005.
- 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 clinicians assessed the patient's capacity and recorded the outcome of the assessment. Best interests decisions were made in accordance with legislation and liaison with the patient's next of kin and other professionals involved in their care.

### Supporting patients to live healthier lives

The practice team and the patient participation group (PPG) recognised the local community was in the second most deprived area in the locality and the link between deprivation and health. As a result, collaborative working took place with external agencies to support local residents live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health.

The PPG had secured funding from Broxtowe Borough Council to promote healthy lifestyle and exercise within the community. A total of six healthy lifestyle events had been

Good

# Are services effective?

## (for example, treatment is effective)

facilitated between 2013 and 2015; and plans were in place to resume them following the extension to the premises was completed in September 2016 and merger with a local practice.

Patients had access to appropriate health assessments and checks. This included health checks for new patients and NHS health checks for patients aged 40–74 years.

- Benchmarking data as at March 2016 showed the practice had achieved the highest number of NHS health checks in the CCG. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- On an annual basis the practice held an active flu vaccination campaign and clinics to ensure eligible patients received the flu vaccine.
- All 24 patients with a learning disability had been offered an annual health check between April 2015 and July 2016.

The published data for 2014/15 showed immunisation rates for vaccinations given to children were at or above the CCG average. For example, childhood immunisation rates for the vaccinations given to:

- under two year olds ranged from 97% to 100% compared to a CCG average of 96% to 97.5%. Practice supplied data for 2015/16 showed the highest uptake rate of baby vaccination rates for children under two was achieved when compared with other local GP practices within the CCG. This data was yet to be verified and published.
- five year olds ranged from 91% to 100% compared to a CCG average of between 91% to 98%.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The 2014/15 Public Health England data showed the practice's cervical cancer screening was above the CCG and national averages. For example:

- 84% of females aged between 25 and 64 years had a record of cervical screening within the target period compared to a CCG average of 78% and national average of 74%. Practice supplied data, yet to be published showed this had increased to 88% as at 31 March 2016.
- 62% of patients between 60 and 69 years had been screened for bowel cancer in the last 30 months (2.5 year) compared to a CCG average of 64.5% and national average of 58%.
- 69% of females aged between 50 and 70 years had been screened for breast cancer in the last three years compared to a CCG average of 78% and national average of 72%. Although performance for breast screening was slightly lower than the local and national average figures, benchmarking data as at September 2015 showed the uptake had increased to 77%. Contributory factors included opportunistic screening and the practice staff proactively inviting eligible patients to attend the screening.

Good

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

Feedback from patients who used the service, those who are close to them and stakeholders was consistently positive about the way staff treat people. For example:

- All of the 74 patient Care Quality Commission comment cards we received were complimentary of the "excellent service" provided by the practice team. The positive feedback related to all staffing groups. Five comment cards also contained less positive feedback relating to telephone access and availability of non-routine appointments.
- The common phrases used to describe staff and the service experienced included: "warm, friendly and efficient", "professional but with compassion", "cannot fault the service" and "I cannot recommend this surgery enough".
- We spoke with four patients including members of the patient participation group (PPG). They described the service as being exceptional and felt staff were highly motivated and inspired to offer care that was kind and promoted their dignity.
- This positive feedback reflected our observations on the inspection day. We observed a strong, visible and person-centred culture.
- Relationships between patients, those close to them and staff were strong, caring and supportive.For example, one GP partner had visited a patient on a weekend and provided them with torches and food, due to concerns for their safety and welfare following a consultation during the week. They had also liaised with the relevant community teams to ensure the person received appropriate care and support.
- In addition, another patient with dementia and well known to reception team often came into the surgery asking for an appointment. The staff automatically ensured a clinician saw this patient and liaised with relevant agencies and / or next of kin.
- Records reviewed and patient feedback demonstrated that staff provided care which exceeded their expectations. Many examples were provided to demonstrate the quality of care provided by the GPs and the practice team.For example, one of the GP partners supported some patients with complex health needs to outpatient appointments, and / or visited them in hospital and liaised with hospital staff to ensure appropriate care and discharge planning took place. This also included teleconference calls with consultants during the patient's follow-up outpatient appointment.
- We also received positive feedback from the health visitor, two community specialist nurses and care co-ordinator regarding the caring nature of staff. They all felt a high level of care was provided for patients, staff were courteous, very helpful and treated patients with dignity and respect.
- Other sources of information that corroborated that staff were caring included the mystery shopper survey undertaken by the CCG, the practice survey on dignity and respect and the friends and family test and recent results; which showed 95% of patients would recommend the practice.

The national GP patient survey results published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was mostly in line with the local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) average of 96% 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 compared to the CCG average of 86% and the national average of 85%.
- 82% of patients said the GP was good at listening to them compared to the CCG and national averages of 89%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and the national average of 97%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.

Good

# Are services caring?

- 88% of patients said the nurse was good at listening to them compared to the CCG average of 92% and the national average of 91%.

Satisfaction ratings for interactions with reception staff were above the local and national averages.

- 96% of patients said they found the receptionists at the practice helpful compared to the CCG average of 93% and national average of 87%.

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

The practice worked to the recognised gold standards framework for end of life care to ensure that patients were actively involved in the planning of their care and treatment. For example, the practice had recently introduced the electronic palliative care co-ordination system (EPaCCS) to enable the recording and sharing of people's preferences and key details about their care at the end of life. Monthly multi-disciplinary meetings were held with the GPs, practice nurse, practice manager, district nurse, and Macmillan nurses to discuss these patients.

Patient feedback from the comment cards we received was overwhelmingly positive about staff being fully committed to encouraging them to be active partners in their care and showing determination to overcoming obstacles to delivering care. For example, one of the GP partners had supported a patient to an outpatient appointment for a scan they might have not attended due to them suffering from agoraphobia (a fear of being in situations where escape might be difficult or that help wouldn't be available if things go wrong).

All patients we spoke with 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.

The national GP patient survey results showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Most of the results were similar to the 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 88% and national averages of 86%.
- 81% of patients said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national averages of 82%.
- 89% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.
- 92% of patients said the nurse gave them enough time compared to the CCG average of 93% and national averages of 92%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

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

People's emotional and social needs were seen as important as their physical needs. For example:

- Over 200 patients had responded to the Age UK 'Fit for the Future' project in 2015. This project was aimed at improving the mental health and physical wellbeing of patients aged 65 and over. Patients completed a lifestyle survey with an Age UK representative and were signposted to relevant local services or activities depending on their need or requirements. This included social groups, community transport schemes, and occupational therapy assessments. Some patients had been supported to access equipment such as raised toilet seats and grab rails and attendance allowance. As a result of this project, £17,656.20 worth of allowances had been received by the participants and the overall gains for the Project was £192,469.25.
- The practice worked with local organisations to promote anti-bullying amongst children in the local community.
- The PPG and the practice manager had received dementia related training at the practice in January 2016, and plans were in place to facilitate a community outreach project to highlight awareness and support in place for affected patients, their families and carers.

Good

# Are services caring?

- The reception staff were made aware by the clinicians of any patient who needed extra consideration if they contacted the surgery. This included vulnerable adults and children discussed in safeguarding meetings and patients with complex health needs. Reception staff were authorised to give these patients a same day appointment without seeking consent from a clinician.
- A congratulations card was sent to new mothers when they had a baby.
- Comment cards received highlighted that staff responded compassionately when they needed help and provided support when required. Specific examples were given of improved outcomes to patients emotional and mental health needs; and support in place for people with learning disability.

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. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 68 patients as carers which represented 1.4% of the practice list. Written information was available to direct carers to the various avenues of support available to them. The practice recognised it had identified and recorded a low percentage of carers. As a result, the nominated carer champion was allocated two hours protected time per month to: contact carers and invite them for a health check, establish if they needed additional support and attend the local carer forum for example. The practice had a carers stand at the annual Macmillan coffee morning held within the practice and other agencies were also in attendance to support carers and their needs.

GPs would usually contact or visit relatives following a patient's death to offer condolences, and signpost them for counselling or support services. A sympathy card was also sent and administrative staff ensured that any existing appointments for deceased patients were cancelled. On some occasions, staff who were particularly involved in the care of the deceased patient attended the funeral.

Outstanding ☆

# 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 Nottingham West clinical commissioning group (CCG) to secure improvements to services where these were identified. For example, the practice had successfully secured primary care transformation funding to build an extension to the existing premises. The extension comprised of five consultation rooms and a treatment room. This would enable the practice to be a local hub for seven day working and accommodate more capacity for medical students and trainee doctors. The building works were scheduled to be completed in September 2016 at the time of our inspection.

There was a proactive approach to understanding the needs of different groups of people and to deliver care that met patients needs and promoted equality. This included people living in vulnerable circumstances or patients with complex health needs. For example:

- The clinicians provided regular primary health services to a secure children's home for 18 vulnerable young people between 10 and 17 years of age. Records reviewed showed the young people spoke highly of the flexibility in the service received and they felt listened to and their care was fully explained. Ofsted had recently rated the local child and adolescent mental health service (CAMHS) outstanding for the input it provided to the children's home, and this included the physical health input from the GPs and practice nurses. Feedback from the CAMHS team who at times carried out joint assessments or sessions with the GPs and practice nurse was very positive; with clinical nurse specialists valuing their knowledge and experience.
- The CCG supplied information showed the practice was is in the top five of local practices to achieve their improving access to psychological therapies target. The practice had a referrals target of 72 and 90 referrals were made. Psychological or talking therapies are recommended by the national institute for health and care excellence for treatment of anxiety disorders and depression (among other things).

The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. For example, the patient participation group (PPG) and the practice team had forged a strong link with the local community through setting up healthy lifestyle events in Stapleford. The events focused on families, older people and people with long term conditions and various organisations were in attendance. For example:

- March 2015 - the PPG organised a health fayre at the New Stapleford community centre. A total of 195 people attended and participated in the activities aimed at raising awareness of the importance of good nutrition, exercise and diet. This included a talk and demonstration on the benefits of Nordic walking, a session on gentle exercise with movement to music, smoothies, information from the gardeners association and the local leisure centre and many more.
- September 2014 - a healthy lifestyle event was held alongside an annual Macmillan event. Over 150 people attended this event and as a direct result 18 people signed up to join the health eating programme held in the surgery. The practice nurse and a dietician held a six week weight management course for registered and non-registered patients following each of four events held in 2014.
- July 2014 - the lifestyle event focused on the health needs of people with allergies, coeliac and lactulose intolerance. A total of 29 people attended and positive feedback was received from the attendees; with some patients attending a healthy eating session facilitated by the practice nurse and dietician within the practice.
- March 2014 – The event focused on pregnant women and families with young children. A total of 21 adults and 18 children attended. The activities included a mother and baby yoga session, Zumba, smoothie bike and information relating to Sure Start, breast feeding and support services for children with disabilities.
- June 2014 – This event focused on raising awareness of the risks associated with excessive consumption of alcohol.
- The PPG in liaison with external agencies had facilitated walks in the local area promoting activity for people who may not otherwise go out for a walk alone and creating friendship opportunities.

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

People's individual needs and preferences were central to the planning and delivery of tailored services. The services offered choice, flexibility and continuity of care. For example:

- The practice had invested in an ultrasound scanning machine to assist in the diagnostic and screening of abdominal aortic aneurysm, foetal position in later pregnancy (to rule out undiagnosed breeches in expectant mothers) and sampling for abnormal uterine bleeding. Steroid injections were offered for a range of conditions such as musculoskeletal problems, osteoarthritis of the hip and knee, tennis elbow and carpal tunnel after ultrasound diagnosis. Minor surgical procedures including, cryotherapy, joint injections and lump excision were also carried out. This extra service provided care closer to patients' homes and reduced the burden on hospital services.
- The practice had purchased a dermatoscope which was used to examine patients with pigmented skin lesions, and images were sent to hospital dermatology consultants. This helped to reduce the requirement for patients to travel to hospital and promoted quicker access to treatment should this be needed. An audit undertaken for patients seen between March and July 2016 showed results from the hospital were received within a period of one and 10 days from the point the referral was made.
- The diabetes nurse specialist attended the practice monthly and delivered a joint clinic with the practice nurse, which included practice initiated insulin therapy. The practice also liaised with diabetic retinopathy screening service and arrangements were in place to ensure patients attended their annual review. The practice's diabetes satisfaction survey results (July 2015) showed all of the respondents were satisfied with the treatment and monitoring of their diabetes, and 96% were very satisfied with continuity of care.
- The practice offered an enhanced service for contraception which included the fitting of implants and coils. A weekly clinic was held on Wednesday and subject to patient demand extra appointments were offered outside of the normal clinic times.
- The practice offered joint consultations with a GP and practice nurse for childhood development checks and vaccinations. The clinicians told us the joint clinics enabled them to identify or follow-up any safeguarding concerns or post-natal depression in new mothers.
- The community midwife facilitated a pre-natal clinic on a Monday afternoon.
- The practice provided a phlebotomy (blood test) service for adults and children.
- The practice offered extended opening hours and appointments five days per week with all clinicians, to facilitate access for working patients who could not attend during normal opening hours.
- The practice team utilised the care coordination service offered by the primary integrated community services ltd (PICS) as well as the monthly multi-disciplinary meetings to identify patients at risk of hospital admission or frail elderly. A direct access number was given to external professionals should they need to speak with staff in an emergency or if they had concerns.
- The practice was proactive in making reasonable adjustments to meet the needs of people whose first language was not English and patients with disabilities or impairments.
- Telephone consultations were available each day for those patients who had difficulty attending the practice due to work commitments.
- The practice team were aware of their responsibilities when managing requests for home visits and clinical staff prioritised the presenting health needs of patient's and the urgency for medical attention.
- The practice was proactive in offering online services to book and cancel GP appointments, order repeat prescriptions and to view summary care records.

### Access to the service

The priority for the practice team was to facilitate ease of access to the service and this was achieved by offering extended opening hours between 7.30am and 7pm Monday to Friday with the exception of Thursday when the practice closed at 6.30pm. Phone lines were closed between 12.30pmand 4.30pm on a Thursday afternoon.

Appointments were generally available from 8.30am to 12pm each morning and 2pm to 6pm. Extended hours appointments with a clinician were provided from 7.30am

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

to 8am daily. Same day appointments were released at 8am for a morning appointment and 2pm for an afternoon appointment. Routine appointments could be booked up to three months in advance.

Feedback from patients we spoke to and 69 comment cards received showed people were able to get appointments when they needed them. We also received five less positive comment cards relating to telephone access and obtaining pre-bookable appointments.

The national GP patient survey results showed patient's satisfaction with how they could access care and treatment was comparable to local and national averages. For example,

- 95% said the last appointment they got was convenient compared to the CCG average of 96% and the national average of 92%.
- 87% 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 89% and the national average of 85%.
- 84% of patients could get through easily to the practice by phone compared to the CCG average of 87% and national average of 73%.
- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 82% and national averages of 76%.
- 76% of patients usually saw or spoke to their preferred GP compared to the CCG average of 69% and the national average of 59%.
- 63% usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 69% and the national average of 65%.

### Listening and learning from concerns and complaints

The practice had effective systems in place to handle concerns and complaints.

- 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. This included information on the practice website, posters and leaflets in the waiting area
- We looked at four complaints and seven concerns received in the last 12 months. We saw that the practice had responded to complaints promptly and provided complainants with explanations and apologies where appropriate. Learning was identified and improvements were made to the quality of care as a result.
- An annual review of complaints was undertaken to detect any themes or trends and to ensure any identified learning and had been embedded. The practice involved the whole practice team in the review of complaints to ensure learning was widely disseminated amongst the staff.

# 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 vision of the practice stated that all staff at Hickings Lane Medical Centre were committed to the provision of high quality patient care and best practice, through the delivery of services which are timely, considerate and responsive to the needs of our patient population, and supported by a clear focus on customer service.

- We spoke with eight members of staff. They were all aware of the vision and values of the practice and knew their responsibilities in relation to these.
- We saw that the regular staff meetings and internal audit work helped to ensure the vision was owned by all staff and embedded in their practice. Staff told us they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- The practice values reflected compassion, dignity, respect and equality; and patient feedback confirmed these values were upheld by the staff.
- There was a strategy in place to support the achievement of the vision and commitments; and this was monitored on a regular basis. This included succession planning and merging with a local practice by April 2017.

### Governance arrangements

The governance and oversight of the practice was well established and effective and enabled the partners to identify risks and continually evaluate and improve the quality of care in their own practice.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies we reviewed were up to date, available to all staff and implemented in their day to day work.
- A comprehensive understanding of the performance of the practice compared to other local practices was maintained. For example, benchmarking information supplied by the CCG showed the practice's highest referring specialty was dermatology with 65% of the patients not discharged following their first outpatient appointment, and 70% of referrals made to trauma and orthopaedics department were deemed to be clinically appropriate. This data reinforced that a high number of appropriate referrals were made by the GPs who had specialist interest / further qualifications in orthopaedics, sport and exercise medicine and dermatology.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. For example, due to the high number of patients not attending their outpatient appointments the practice responded by producing and distributing leaflets to relevant patients to remind them to either attend or reschedule their appointment.
- There were effective arrangements for identifying, recording and managing risks, and implementing mitigating actions.

### Leadership and culture

The GP partners and practice manager had the experience, capacity and capability to run the practice and ensure high quality care.

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

- Staff spoke highly of the open culture, the constructive engagement within the practice and motivation to succeed. They gave examples to reflect the strong team working arrangements in place and articulated the shared focus to improve the quality of care for patients.
- The leadership team was described by staff as being visible in the practice and approachable. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.
- 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.
- Staff said they felt respected, valued and supported by the GPs, nurses and the practice manager.

There was also a clear commitment to improving the health of the wider patient community and the partners were involved in a number of initiatives and lead roles to facilitate improvements to health and wellbeing in the locality. The two GP partners had leadership roles outside of the practice which enabled them to contribute to the

# Are services well-led?

Outstanding ☆

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

development of specific care pathways at a strategic level. For example, one GP partner was the CCG lead in orthopaedic, musculosketal sports injuries pathways due to their extensive experience of facilitating orthopaedics clinics in the community. Another GP partner was involved in working groups focusing on gynaecology and menorrhagia pathways.

The lead GP partner had produced for the local newspaper (Nottingham Post) a series of educational and health related articles for the public, and used their strategic involvement in the local health and wellbeing board to promote healthy lifestyles for local residents. Their strategic role also allowed input into the improvement of health services through strong integration of social care, and the NHS through a budget called the Better Care Fund. The Better Care Fund provides financial support for councils and NHS organisations to jointly plan and deliver local services.

### 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 patient participation group (PPG), surveys, concerns and complaints received. The results of the practice and national patient surveys showed high levels of patient satisfaction. The most recent friends and family test results showed 95% of patients would recommend the practice to others.
- We spoke with four members of the PPG. They told us they felt valued and listened to by the leadership team. PPG meetings were held regularly (at least bi-monthly) and in attendance was the practice manager, GP and / or practice nurse. The PPG carried out patient surveys and developed action plans to ensure improvements were monitored.They also produced seasonal newsletters to disseminate key information to patients.
- The PPG demonstrated strong leadership to lead and drive the patient engagement agenda.For example, the CCG described the PPG as being very successful both in its role within the practice and within the CCG's patient reference group. The group have run numerous health events within the community and raised funds for charity. A member of the PPG recently went above and beyond their role to support a neighbouring practice's consultation meeting with more than 140 patients in attendance.
- The practice had gathered feedback from staff through informal discussions, formal meetings and appraisals.
- There were high levels of staff satisfaction and staff spoke highly of the practice as a pleasant place to work. They were proud of their achievements and this included giving up their free time to participate in the community healthy lifestyle events with the PPG.
- The GP partners and managers cared for the welfare of their employees and some staff we spoke to gave examples of the support and care they had received during difficult times and / or bereavement of a family member.

### Continuous improvement

A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. For example:

- The GP partners held strategic roles in various committees related to health scrutiny public health, adult social care and being vice chair of child and adolescent services.The practice provided many examples to demonstrate the impact this had on service development and delivery within the local area.
- For example, one of the GP partner's actively promoted the need for local planning departments to engage with healthcare providers at the earliest possible point in any development, to make sure adequate services were in place. The GP had for example, attended a planning meeting where a 140 bedded care home was about to be built, and consideration of local healthcare provisions had not been taken account of by the planning department.

New evidence-based techniques were used to support the delivery of high-quality care. For example, the practice started undertaking abdominal aortic aneurysm screening (AAA) for all males aged 65 and over in 2007 before the national programme was rolled out in 2009. A number of aortic aneurysms were identified and we saw evidence of patients receiving appropriate treatment as a result.

# Are services well-led?

Outstanding ☆

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

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- The practice had secured funding from NHS England, to pilot the role of clinical pharmacists working in general practice. The practice had an allocated pharmacist who supported them in lowering their prescribing rates through review and audit.
- Hickings lane medical centre is a teaching practice and records reviewed showed previous students had been provided with good learning opportunities. At the time of inspection, medical students in their first, second, fourth and fifth year were on placement.
- A fifth year medical student attached to the practice and supervised by the GP partners was selected runner up for the 2015/16 primary care clinical governance prize for their clinical audit titled “an audit of the prescription of high dose opioids in non-cancer patients. The audit was runner up to 90 projects reviewed as being excellent by practice GP tutors at the University of Nottingham medical school.
- The practice took part in the annual community project which entailed year five medical students being allocated to patients for 18 months to follow the patients journey.
- The association with the fifth year students allowed regular auditing to take place which resulted in improved practice.
- To ensure nurses were supported with the revalidation process with the Nursing Midwifery Council, bi-monthly clinical supervision meetings had been planned to start in September 2016 with other nurses from a local practice.
- The practice also aspired to offer more community based services and facilities to train doctors following the completion of the merger and the extension to the premises.