Sunrise Medical Practice - Radford Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sunrise Medical Practice on 15th September 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. We found an open and transparent culture where staff felt supported. A robust system was in place where information about safety was recorded, monitored, appropriately reviewed and addressed. Lessons were shared to make sure action was taken to improve safety in the practice.
- Risks to patients were assessed and well managed. This included health and safety considerations such as fire risk assessments, checks that equipment was safe to use, infection control measures and appropriate standards of cleanliness and hygiene. Medicines management kept patients safe.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The practice adopted stringent measures to ensure their patients' health records were accurate, up to date and care plans updated if necessary. Patients we spoke with felt involved in decision making about their care. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. This was shown in patient feedback about the practice.
- Information about services and how to complain was available in some areas and easy to understand. Complaints we looked at were addressed and handled effectively in a timely way with an apology given to the patient if required.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and external specialists which it acted on to improve the service in place.

Summary of findings

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. We found robust systems were in place for addressing safeguarding concerns. This was demonstrated in effective collaborative working between a GP and health visitor which prevented a referral into social care.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality taking into account the national variation in population groups and that the practice served a predominantly healthy student population. This was demonstrated in its performance for diabetes and asthma related indictators which was above the local and national averages, but dementia diagnosis rate which was significantly under the averages. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked in collaboration with multidisciplinary teams which ensured the most effective outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Despite a low number of responses to the national GP patient survey, the practice was in line with local and national averages for its satisfaction scores on consultations with clinicians. Patient comment cards highlighted that staff responded compassionately when patients needed help and support. Patients we spoke with felt their privacy and dignity were respected.

Information for patients about the services available was easy to understand and accessible. Carers were identified by their GP through the practice's computer system, and staff told us they also knew their patients with individual needs well. During our

Summary of findings

inspection, we saw how two of the clinicians responded to a concerned carer which led to a home visit being undertaken. We also saw that staff treated other patients with kindness and respect, and maintained confidentiality. Translation services were available to patients who did not have English as a first language and this was clearly displayed in the practice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) and other stakeholders including Nottingham City Council, Public Health England and a local university to secure improvements to services where these were identified. This included work to look at the process for screening international students for TB and identifying those individuals at risk, participation in a pilot service to tackle eating disorders in students and direct access to physiotherapy service and sexual health services. The practice sought to address the needs of its patients, particularly in relation to mental health. This was demonstrated in its corroborative working with a local university which also identified patients in need of medical care.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent and routine appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available, easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. The patient participation group (PPG) was small but active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The practice had supported other research within primary care and had become research accredited. Their studies, some of which were ongoing included: smoking cessation, helping urgent care users cope with distress about physical complaints, a drug research study and a dietary supplement for people with type II diabetes.

One of the partners had worked on the CCG board and as a prescribing lead at a sub group of Nottingham CCG. This role which involved sharing information with the medicines management board of the CCG enabled developments in the practice to be made. For example, a shared care protocol was required and developed for the issue of particular classified drugs.

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 offered proactive, personalised care to meet the needs of the older people in its population was part of an enhanced service for diagnosis and support for people with dementia. Older patients were invited to attend for health checks on an annual basis. Health assessments included whether patients had long term conditions, mental health problems or whether they were a carer.

The practice had a low number of older people on its register, 15 people aged 75 and over at the time of our inspection. The practice knew each of their older patients at the practice. The practice was part of an initiative to reduce unplanned hospital admissions, and had created a register of those considered most at risk, which included older people. Care plans were created for those and tailored to the needs of each patient. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice performance in relation to seasonal flu vaccines administered to those aged 65 or over was higher than the national average.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP which they could change if required and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had a small number of patients on its palliative care register, five at the time of our inspection. End of life care pathways were in place.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and those who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Whilst the

practice had a low number of babies and young children, 41 children aged between 0 to 4 years at the time of our inspection, immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of multidisciplinary team working.

The practice had received the You're Welcome Accreditation, which was aimed at making health services for young people friendly.

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. In response to patient feedback, the practice introduced a sit and wait appointment system on Monday mornings at its Clifton site and reviewed the effectiveness of this service. The practice offered extended hours opening one evening a week at both of its sites.

The practice actively sought to engage with students by their attendance on campus during freshers week, and worked in collaboration with the university to run roadshows on relevant issues such as sexual health screening. The roadshows attracted approximately 700 to 800 students.

The practice targeted their student population with other information including the meningitis vaccination, sexual health screening, mental health services and domestic violence.

The practice offered a level 1 sexual health service which offered asymptomatic STI screening for under 25's as well as C – Card registration which offered free condoms to patients who registered with the service.

Information was provided to help patients understand the care available to them in formats they were comfortable with such as the NHS Nottingham City App which was a guide for choosing the right service. It also utilised text messaging for health promotion purposes and to remind patients about appointments made and how they could be cancelled if required.

The practice was proactive in offering online services, and were part of the initiative of remote care monitoring which was designed to

assist students when away from university. A local collection point for pharmacy items prescribed and dispensed was based at the university campus to negate the necessity for student travel to a pharmacy.

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 those with a learning disability. The practice recorded 3 patients as having a learning disability. It had carried out annual health checks for 2 of those people and were in the process of removing the third patient from the register as they were no longer eligible to remain on it. The practice offered longer appointments for those people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. The practice staff had participated in a pilot which involved domestic abuse project training. (known as IRIS)

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.

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)

74% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had estimated from a review of a sample of appointments with GPs that around one third of the consultations with a clinician were regarding mental health issues. It had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. The practice had undertaken shared learning with

peers regarding patients who self harmed or were at risk of suicide. The practice held positive relationships with university staff which ensured patients identified at risk were seen quickly and had effective continuity of care.

The practice was actively involved in a Talk About Self Harm project (TASH) jointly run by two local universities which sought to improve self help strategies for people who self harmed.

Staff had received training on how to care for people with mental health needs and dementia. We found nursing staff at the practice had undertaken additional training into self harm and suicide.

The practice had worked in partnership with the CCG and two local universities in a pilot to tackle eating disorders. The practice had offered a weekly drop in clinic to signpost and provide brief interventions for patients with mild to moderate eating disorders. The service had continued to be delivered from the local university site by another provider following a tender exercise.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4th July 2015 showed the practice performance was reflective of local and national averages. There were 20 responses, a return rate of 4.4%. Data was collected during the periods of July to September 2014 and January to March 2015. A low response rate was indicative of student absence from academic term time when part of the survey was issued. The practice also undertook their own survey to seek patient feedback. They received 106 responses during December 2014.

The results provided to us by the practice have been included to add statistical value to the low level response in the national survey.

- 90% found the last GP they saw or spoke to was good at giving them enough time compared with a CCG average of 85% and a national average of 87% (Practice survey also found 90%)
- 88% found the last GP they saw or spoke to was good at explaining tests and treatments compared with a CCG average of 85% and a national average of 86% (Practice survey found 77%)
- 73% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 62% and a national average of 65% (Practice survey found 79%)
- 83% found it easy to get through to this surgery by phone compared with a CCG average of 75% and a national average of 73% (Practice survey found 73%)
- 83% found they were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 83% and a national average of 85% (practice survey found 100%)
- 85% found the receptionists at the practice helpful compared with a CCG average of 87% and a national average of 87% (Practice survey found 94%)
- 80% found the last nurse they saw or spoke to was good at giving them enough time compared with a CCG average of 92% and a national average of 92% (Practice survey also found 79%)
- 86% found the last nurse they spoke to was good at explaining tests and treatments compared with a CCG average of 91% and a national average of 90% (Practice survey found 78%)
- 70% describe their overall experience of this surgery as good compared with a CCG average of 84% and a national average of 85% (Practice survey found 77%)

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards, 35 of which were positive about the standard of care received. 2 comments included that the patients had waited a long time to be seen on arrival at the practice. The majority of the comment cards included the words excellent, caring, dignity and respect. One comment included that nothing was too much trouble for the practice, and staff go the extra mile.

Sunrise Medical Practice - Radford Health Centre

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, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Sunrise Medical Practice - Radford Health Centre

Sunrise Medical Practice is located in Radford, which is in an area of Nottinghamshire. It provides its services to residents within the NG7 postcode area. It also provides services within an outer boundary which extends to the NG1 postcode area. These are mostly urban and suburban districts. We visited this site as part of this inspection.

The practice has a branch surgery located at Clifton campus, Nottingham Trent University. We did not visit the practice's branch surgery located at Clifton Campus, Nottingham Trent University, George Eliot Building, Clifton Lane, Nottingham NG11 8NS as part of this inspection.

The practice is distinctive as it is a part university and part community practice with patients who have differing needs.

The practice currently has a list size of approximately 6,000 patients. Around 5,000 of these patients attend the branch practice at the university. Patients mainly consist of students and staff. Between 1200 to 1500 new students register at the practice at the start of each academic year so the practice list size fluctuates to incorporate those who start and finish their academic studies. The practice therefore has a large annual patient turnover of approximately 35%. Approximately 1,000 patients attend the Radford site.

The practice holds a Personal Medical Services (PMS) contract which is a locally agreed contract between NHS England and a GP to deliver care to the public. The practice provides GP services commissioned by NHS Nottingham City.

The practice is managed by two GP partners, (both male). One works on a full time basis and one in 50% of a full time role. (0.5 Whole Time Equivalent, WTE) They are supported by clinical staff; one part time female locum GP (0.1 WTE), two part time female practice nurses, one part time male locum nurse prescriber and a female healthcare assistant who has a dual role as the senior receptionist. The practice also employs a practice manager, assistant manager and a team of reception, clerical and administrative staff. The practice is a teaching practice where three junior doctors work in a year.

The site at Radford is open from 8.30am to 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays and on Thursdays from 8.30am to 12.30pm. Appointments are available Mondays and Tuesdays from 9.30am to 11.00am, 4.00pm to 5.30pm with an extended hours surgery open from 6.30pm to 8.30pm on Mondays. Wednesday appointments are available from 11.15am to 12.15pm and

between 3.30pm to 5.00pm. Thursday appointments are available from 11.30am to 12.30pm and on Fridays from 9.00 to 10.30am and between 2.30pm to 4.00pm. The practice is closed during weekends.

The Clifton site is open from 8.45am to 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays and on Thursdays from 8.45am to 12.30pm. Appointments are available Mondays from 9.30am to 11.30am and between 3.30pm to 5.30pm, Tuesdays from 9.30am to 12.00pm and between 2.00pm to 6.00pm. Wednesday appointments are available from 9.00am to 11.00am, 2.30pm to 6.30pm with an extended hours surgery open until 8.30pm. Thursday appointments are available from 9.00am to 10.30am and on Fridays from 12.00pm to 2.00pm and between 2.00pm to 6.00pm. The branch is closed during weekends.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided currently by Nottingham Emergency Medical Services. When the practice is closed, there is a recorded message giving out of hours details.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This 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.

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, unless stated otherwise. Quality and Outcomes Framework data we obtained included both the Radford Practice and Clifton University Campus branch mixed together.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 September 2015. During our visit we spoke with a range of staff which included two GPs, the practice manager, two nurses, the healthcare assistant, administration staff and we spoke with patients who used the service.

We observed how people were being cared for and talked with patients including a family member and reviewed the personal care or treatment records of patients. We reviewed 37 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager or one of the GP partners of clinical concerns, significant events or of any incidents. Significant event forms were routinely completed for such reporting. We asked a number of staff we spoke with to provide examples of significant events they had reported or ones which they had knowledge of and the subsequent learning that had taken place.

All complaints received by the practice were recorded and considered as significant events. The practice carried out an analysis of all significant events.

We reviewed safety records, incident reports and minutes of weekly meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a member of staff had forgotten to place a box of vaccines into the refrigerator which resulted in the disposal of the vaccines and a reminder of the daily process to be followed. Another incident recorded included an omission of patient information made on a patient discharge summary by an external clinician. This resulted in an agreement amongst the clinicians to scrutinise accompanying paperwork to patients' discharge summaries.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. We found a robust system was in place in respect of the processing of alerts received by the practice, for example, Medicines and Healthcare Products Regulatory Agency alerts (MHRA) and National Patient Safety Alerts.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were up to date and accessible to all staff. We saw information in the form of flow charts and key contact details in clinical treatment areas. One of the practice nurses was a lead for safeguarding. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The clinicians attended regular safeguarding meetings where vulnerable patients had been identified. We saw that the practice had a process in place for flagging vulnerable patients on their computer system.
- All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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). Whilst a chaperone policy was in place, we did not see information displayed within the reception area or within the clinical practice areas to advise patients of this. We were later informed by the practice that information would flash up on the patient electronic calling display board in reception. We had not seen this however during our inspection. The practice told us that for those patients who had a hearing or visual impairment, an alert was placed on the patient's record which receptionists would see when they arrived for their appointment. Additional support would then be offered.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and regular fire drills were carried out. 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 also 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. This was last tested in July 2015 and the results showed no concerns.
- Appropriate standards of cleanliness and hygiene were followed. 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. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken. We saw an action plan formulated as a result of the latest audit undertaken and that action had been taken to address issues identified.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security).
- There was a robust process in place for the uploading and scanning of letters received by the practice following patient hospital admissions and discharges. Checks were then made by GPs and re checked by the practice nurse to ensure changes in medications were altered in the system, the patient reviewed, care plans updated if necessary and clinical coding accurately recorded.
- Regular medication audits were carried out with the support of the local clinical commissioning group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff needed to meet patients' needs amongst all staff roles. As the majority of patients were from the student population, annual leave was planned in line with student holiday periods. Staff sickness leave was effectively covered. Staffing levels were increased accordingly during busy periods such as the student registration period at the start of the academic year.

Arrangements to deal with 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. The practice had a defibrillator available on the premises which was shared with the other three practices on site. Responsibility for checking the equipment was also shared and we found that appropriate checks had been undertaken. We also found that oxygen was available with full cylinders. There was a first aid kit and accident book 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 fit for use.

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. It was last reviewed in March 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and staff used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed. We saw evidence that a nurse used the latest NICE guidelines for the care and management of patients with asthma. This was reflected in a personalised care plan we reviewed. NICE guidelines were also used during a recent clinical audit conducted into the risk of stroke for patients who had atrial fibrillation (irregular heart beat).

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework(QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Results showed that the practice achieved 88.3% of the total number of points available. Data from 2013/2014 QOF showed;

- Performance for diabetes related indicators was 90.3% which was above the clinical commission group (CCG) average by 5.2% and 0.2% above the national average.
- Performance for asthma related indicators was 100% which was above the CCG average by 1.8% and 2.8% above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100% which was above the CCG average by 11.1% and 11.6% above national average.
- Performance for mental health related and hypertension indicators was 80.8% which was below the CCG average by 9.1% and 10.1 below national average. The practice told us that their performance for mental health was lower than average because of their large population group of students who were transient and were often moving between their permanent homes and their university base. They told us this made it more difficult for them to monitor, review and track them. The practice also informed us they had a lower than average performance for hypertension indicators as a result of having a small number of patients who fitted into this group. This had the effect of distorting the practice's statistics against local and national averages.
- The dementia diagnosis rate of the practice was 0% which was below the CCG average by 89% and 93.4% below national average. The practice's main population group (around 5,000 of its 6,000 patients) comprised of students.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We looked at two clinical audits. Both of these audits were undertaken in June 2015 and had demonstrable outcomes. For example, one of the audits focussed on identifying patients who had a diagnosis of diabetes and had not received retinopathy screening (DRS). The audit identified ten patients who were subsequently referred to the diabetic retinopathy service (DRS). Learning outcomes were identified which included a quarterly review of all patients with diabetes to ensure they were known to the DRS or under care of an opthamologist. The audit was scheduled for repeat in December 2015, so had not completed a full audit cycle. We were passed further examples of audits undertaken following our inspection. These were completed cycles and learning outcomes identified.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, the practice held a peer review meeting with a neighbouring practice to share learning in respect of patients who were at risk of self harm or suicide. This was undertaken in response to a significant event recorded by the practice and their analysis of risks identified within their student population group. Learning outcomes included the flagging of patient records following patient attendance at accident and emergency (A & E) and if appropriate, would trigger a telephone call or invitation from the patient's GP to attend an appointment to discuss future management of mental health needs. We saw evidence which

supported the positive working relationship between the practice and the university in respect of the referral of students with mental health concerns into the appropriate clinical care environment.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- 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 these learning needs and to cover the scope of their work. This included ongoing support during clinical sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the previous 12 months of our inspection.
- Records reviewed showed that staff had received training which included: safeguarding, fire procedures, health and safety, infection control, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

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 test results. For example, we saw a care plan sent to a patient and stored within their notes. This included a detailed action plan which had been discussed with the patient. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place regularly and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, and those at risk of developing a long-term condition. The practice targeted their student population with information including the meningitis vaccination, contraception, mental health services and domestic violence. The practice staff had participated in a pilot which involved domestic abuse project training. (IRIS). The practice had also received the You're Welcome Accreditation, which was aimed at making health services young people friendly. Information was provided to help patients understand the care available to them in formats they were comfortable with such as the NHS Nottingham City mobile App which was a guide for choosing the right service, text messaging and their internet site.

Patients who required smoking cessation were signposted to the local New Leaf support service. The practice informed us that New Leaf had seen nine of the practice's patients during 2014 to 2015 and the practice's clinicians had provided 252 patients with smoking cessation advice. These patients accounted for 40% of known smokers registered at the practice. We had not validated this data.

The practice was participating in a locally enhanced service to identify and reduce alcohol related risk in patients. The practice told us that that nine patients had been advised to attend alcohol support services in 2014 to 2015. We had not validated this data.

Good

Are services effective?

(for example, treatment is effective)

The practice operated a sexual health screening clinic as part of a locally enhanced service. Practice supplied data indicated that 234 patients had been screened for sexually transmitted infections during 2014 to 2015.

The practice had a comprehensive screening programme. The practice had a higher than national average female population from aged 15 to 24 years, but they had a much lower than national average female population from aged 25 to 64. Data from 2013/14 showed the practice's uptake for the cervical screening programme was 66.1%, which was below the CCG average by 15.7% and below the national average by 15.8%. The practice supplied performance data for 2014/15 which indicated an improvement of a total 70% uptake. 2014/15 data had yet to be validated.

There was a policy to offer a reminder by way of a letter sent to patients who did not attend for their cervical screening test. Patient records were then flagged for those who did not make contact. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

The practice had a very low number of patients registered within the 0-5 age range. Practice data supplied to us indicated there were currently 41 patients aged 0-4. Childhood immunisation rates for the vaccinations given were comparable with the CCG averages but to be considered in light of the low number of registered patients. For example, childhood immunisation rates in 2013/14 for the vaccinations given to under two year olds were 100% with the exception of Meningitis C at 14.3%. These were higher than the CCG average which ranged from 79.2% to 96.3% with Meningitis C at 1.9%. Vaccinations administered to five year olds were 50% and below the CCG average which ranged from 86.9% to 95.4% but this significant variation could be attributed to the small sample size.

Flu vaccination rates for the over 65s were 78.38%, and at risk groups 48.84%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that 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.

Thirty five of the thirty seven patient CQC comment cards we received were extremely positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two comment cards however stated that the patients had waited a long time to be seen once arriving for their appointments. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We also spoke with a member of the patient participation group (PPG) on the day of our inspection. The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. They told us they were satisfied with the care provided by the practice and said from their experience, the doctors had ensured smooth continuity of care if a diagnosis was not immediate. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in July 2015 showed patients were happy with how they were treated. Despite the low number of responses to the survey, the practice was in line with the clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 88% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 83% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.
- 85% patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and 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 on the comment cards we received was also positive and aligned with these views.

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

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and national average of 86%.
- 88% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We

Good

Are services caring?

were told by practice staff that they did not like to use friends or family of patients as interpretors. Reception and nursing staff described the advocacy services available and how they were used when required.

Patient and carer support to cope emotionally with care and treatment

Notices in the shared patient waiting room told patients how to access a number of support groups and organisations. This included a leaflet offering carers support.

The practice's computer system alerted GPs if a patient was also a carer. The practice had a very small number of carers. Their main population group were young healthy students away from home. Twelve carers were identified at the time of our inspection. The receptionists and clinical staff stated they knew their patients with individual needs well. During our inspection we saw how a nurse responded to a concerned carer. As a result of the nurse's concern, one of the GP partners was spoken with and the GP undertook a home visit.

We did not see information displayed regarding bereavement support in the waiting room or in other patient accessible areas although there was a leaflet in a corridor outside treatment areas which gave carers information on palliative care. We were informed that because of the small number of patients at the practice this may affect, patients would be seen individually on an ad hoc basis.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. For example, the practice undertook a Joint Student Health Needs Assessment with Nottingham City Council, public health department. This identified initiatives which the practice actively participated in such as an eating disorders in students services clinic and a sports physiotherapy clinic.

The practice had also hosted a specialist direct access physiotherapy service at its Radford site which was due to be rolled out to its Clifton site. The service was designed to provide an initial assessment and advice to patients. It did not provide an ongoing course of physiotherapy at the practice. Appointments were offered to patients at the practice weekly on Wednesday mornings. The practice told us that between April to June 2015, 52 patients had accessed the service.

The provider of the service which also operated in 16 other practices, stated that they estimated over half of the patients seen across the sites had not needed a GP appointment first. They told us that utilisation of the service's appointments was above 80% with 8% needed to be seen by the GP after seeing the physiotherapist, 2% required diagnostics, 60% self managed within the service and 25% referred for further physiotherapy. The provider had compared three months' data from May to July 2014 with data in 2015. They told us that that referral rates to the main physiotherapy service had therefore potentially reduced.

The practice had worked with the local TB services and Public Health England to examine the process for screening international students which the practice told us accounted for approximately 10% of all new registrations. Individuals were identified as a result and referred to the TB services for screening. The practice also met with the Student Services Manager at the university on a regular basis where planned activities were discussed and agreed. As an example, a roadshow was run by the practice which aimed to educate their student population group about sexual health screening and advice.

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

- The practice offered later evening appointments on Monday evenings at their Radford site from 6.30pm to 8.30pm and on Wednesday evenings at their Clifton site from 6.30pm to 8.30pm for patients who could not attend during normal opening hours.
- The practice introduced sit and wait appointments for their student population on Monday mornings at the Clifton site in response to patient feedback.
- There were longer appointments available for people with long term conditions.
- Home visits were available for older patients and patients who found it hard to attend the practice.
- Urgent access appointments were available for all patients which offered them access to a same day telephone consultation and follow up arrangements such as a home visit or an appointment at the practice if needed.
- There were disabled facilities, hearing loop and translation services available.
- From April 2015, as part of a pilot exercise, the practice offered patients direct physiotherapist access at the Radford site. This was also due to be rolled out to the Clifton site.
- The practice provided a level 1 sexual health screening clinic which included advice and guidance. The practice also operated as a C-Card registration and distribution centre offering free condoms to registered patients under 25.
- The practice provided students at its branch site, access to a Lets Talk Wellbeing Service which sought to address mild to common mental health problems.
- The practice were able to refer student patients to an eating disorder clinic based at the university.
- The practice provided its student population with a local collection point on campus for pharmacy items dispensed.

Access to the service

The Radford site was open between Monday, Tuesday, Wednesday and Friday 8.30am to 6.30pm and Thursday 8.30am to 12.30pm. The Clifton Site was open Monday, Tuesday, Wednesday and Friday 8.45am to 6.30pm and Thursday 8.45am to 12.30pm.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Appointments at the Radford site were available Mondays and Tuesdays from 9.30am to 11.00am, 4.00pm to 5.30pm with an extended hours surgery open from 6.30pm to 8.30pm on Mondays. Wednesday appointments were available from 11.15am to 12.15pm and between 3.30pm to 5.00pm. Thursday appointments were available from 11.30am to 12.30pm and on Fridays from 9.00am to 10.30am and between 2.30pm to 4.00pm.

Appointments at the Clifton site were available from 8.45am to 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays and on Thursdays from 8.45am to 12.30pm. Appointments were available Mondays from 9.30am to 11.30am and between 3.30pm to 5.30pm, Tuesdays from 9.30am to 12.00pm and between 2:00pm to 6:00pm. Wednesday appointments were available from 9.00am to 11.00am, 2.30pm to 6.30pm with an extended hours surgery open until 8.30pm. Thursday appointments were available from 9.00am to 10.30am and on Fridays from 12.00pm to 2.00pm and between 2.00pm to 6.00pm.

Routine appointments could be pre-booked in advance in person, by telephone or online. For routine appointments, the practice offered an appointment time within a maximum of 72 hours.

Urgent appointments were also available for people that needed them. During our inspection we found same day GP appointments available for urgent and routine clinical matters. We spoke with one patient who had telephoned for an appointment and was told he could attend the practice the same afternoon.

We found that the availability of appointments to see a female GP were limited. The practice had employed a regular female locum GP who was available for three hours per week to see patients. The practice had also used other locum practitioners as and when required.

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 and people we spoke to on the day were able to get appointments when they needed them. We found similar results to the practice's own survey undertaken. For example, the national survey found:

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 83% patients said they could get through easily to the surgery by phone compared to the CCG average of 75% and national average of 73%.
- 68% patients described their experience of making an appointment as good compared to the CCG average of 73% and national average of 73%.
- 73% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We spoke with two receptionists who told us that they would pass a complainant's details on to the practice manager and the practice manager would call the patient back. Although the two receptionists we spoke with were not aware of a complaints leaflet, one was located within a patient information folder. Nursing staff we spoke with were aware of a complaints form and told us they would ask a patient to complete it and then it would be passed to the practice manager.

We saw that some limited information was available to help patients understand the complaints system in a corridor which was used by patients to access the clinicians. The practice website contained more detailed information for patients about how to make a complaint. Patients we spoke with told us they would raise a concern verbally but stated they were unclear if this was the correct process as had not had cause to complain.

We looked at 11 complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way, with openness and transparency and in line with the practice's own complaints policy. If required, an apology had been given to the complainant.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a patient complaint regarding a rushed appointment and the treatment door left open during part of the consultation was dealt with by way of discussion with the named clinician and a full apology given to the patient. The clinician was asked to record the learning points which had arisen from the complaint. All of the staff

Good

Are services responsive to people's needs?

(for example, to feedback?)

we spoke with told us about weekly meetings they attended where complaints and concerns were discussed and learning outcomes identified. This was supported by evidence we reviewed of records held.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had made changes accordingly through reviews and listening to staff and patients. For example, the practice had produced a document for its patients titled You said, we did and had commissioned a review in to improvement in patient access. The practice had a mission statement and staff knew and understood the values. They told us they were supported to deliver these. The practice had business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place. For example;

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice demonstrated a proactive approach by identifying challenges it faced within the future for example, budgetary cuts, GP retirement, employment of the correct skill mix. This was balanced with the practice's identification of opportunities to be sought for example, further research, increased patient size list, increased efficiency and the recognition of the team already in place.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Records reviewed showed these were held weekly. Staff told us that there was an open blame free culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that annual team away days were held. Staff said they felt respected, valued and supported, particularly by the practice manager and partners in the practice. 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.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' views and engaging them in the delivery of the service. Feedback had been gathered from patients through the patient participation group (PPG) at both sites and through surveys and complaints received. There was an active PPG at the Radford site which met on a regular basis, and discussed proposals for improvements with the practice management team. The practice manager had adopted a proactive approach at the Clifton university site to engage with students and utilised opportunities with the university, for example their attendance at health promotion forums. We saw evidence of improvement as a result of patient engagement. This included the setting up and promotion of online services which it was anticipated would be useful for students away from campus during holiday periods.

The practice had also gathered feedback from staff through meetings, appraisals and discussion. Staff told us they felt involved and engaged to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff and those we spoke with said they would feel confident in reporting any concerns.

Innovation

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

Are services well-led?

Good

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

team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice manager was part of a steering group in a Talk About Self Harm project (TASH) jointly run by two local universities which sought to improve self help strategies for people who self harmed. This work included the production of a self harm booklet which had been given to six patients at the practice (at the time of our inspection) to increase their awareness of the condition and how to seek support. The practice told us that whilst they had not formally collated patient feedback it had been positive and that one patient had commented to them that it showed the practice took self harm seriously. We found nursing staff at the practice had undertaken training into self harm and suicide.

The practice had worked in partnership with the CCG and two local universities in a pilot to support people with eating disorders. The practice offered a weekly drop in clinic to signpost and provide brief interventions for patients with mild to moderate eating disorders; and a series of six sessions of cognitive behaviour therapy (CBT) specifically for students. The service had continued to be delivered from the Nottingham Trent University site by another provider following a tender exercise.

The practice had supported other research within primary care and had become research accredited. Their studies, some of which were ongoing included: smoking cessation, helping urgent care users cope with distress about physical complaints, a drug research study and a dietary supplement for people with type II diabetes. We asked the practice about the outcome of these initiatives and we were informed that such evidence would be provided by the research bodies at a later date. The practice had yet to embed evidence based metrics into their evaluation process.

One of the GP partners had worked on the CCG board and as a prescribing lead at a sub group of Nottingham CCG. This role which involved sharing information with the medicines management board of the CCG enabled developments in the practice to be made. For example, a shared care protocol was required and developed for the issue of particular classified drugs.