Woodside Surgery

Quality Report

31 Mansfield Road
Skegby
Sutton in Ashfield
Nottinghamshire
NG17 3ED
Tel: 01623 513 516
Website: www.woodsidesurgery-skegby.nhs.uk

Date of inspection visit: 11 March 2015
Date of publication: 30/07/2015

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 Woodside Surgery on 11 March 2015. Overall the practice is rated as good.

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

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. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named 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 the management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Carry out a risk assessment for GPs not carrying emergency medicines in their GP home visit bags.

Summary of findings

- Ensure that the practice's whistleblowing policy includes reference to Care Quality Commission (CQC) & NHS England (NHSE) to ensure staff are aware of all agencies they could contact.
- Ensure that all carers are identified on the records system to ensure appropriate information, advice and support for them.
- Carry out appraisals for all staff

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Robust safeguarding systems were in pace to protect children ad vulnerable adults from harm. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice had a whistleblowing policy in place but this required updating. Risks to patients were assessed and well managed. However we found that the practice did not have risk assessments in place for GPs not carrying emergency medicines. Additionally we found the practice did not always record when patients were carers. There were enough staff to keep people safe. Processes were in place to check medicines were within their expiry date and suitable for use.

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 Clinical Commissioning Group (CCG) area. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity; ensuring patients were able to give informed consent to care and health promotion.

Staff had received training appropriate to their roles and any further training needs have been identified and planned. For example the health care assistant had received additional training to enable them to carry out health screening.

Staff told us they felt valued and had access to training and professional development. However we noted that due to staff absence not all staff had received their annual appraisal. The practice worked with multidisciplinary teams to ensure the best outcomes for patients. For example the CCG prescribing advisor visited the practice weekly to review medicines and prescriptions and regular multi-disciplinary meetings were held to discuss patients with complex needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care, particularly for care received from the nursing team and waiting times for appointments. Patients said they

Summary of findings

were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Practice staff demonstrated examples of additional help and support they had offered to patients, their careers and families, beyond what was expected of their role. For example support of anxious patients, compassion following bereavement and welfare checks for housebound patients in poor weather.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named 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. For example, the building had ground level access and toilets which were accessible to people in wheelchairs, parents with push chairs and those with reduced mobility. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Practice staff had access to translation services to assist people for whom English was not their first language. Learning from complaints with staff and other stakeholders was discussed at team meetings.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). A PPG is made up of patients of the practice who work with staff to improve the service and the quality of care. Staff had received inductions and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and home visits for some procedures and health checks were available.

At times of bad weather, home visits were carried out by the practice nurse to patients who may be at risk of fall who required procedures such as dressing changes or blood tests.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people such as rheumatoid arthritis and coronary heart disease. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Opportunistic screening and testing was carried out for patients who had concerns about their memory.

The practice monitored patients at risk of hospital admission and worked with local practices and other agencies to maintain a register of these patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. A comprehensive annual review was offered to patients with long term conditions such as, diabetes, asthma, chronic heart disease (CHD) and hypertension (high blood pressure). Where possible reviews were carried out by the same nurse or other clinician to ensure continuity of care for patients. Additional training had been provided to the healthcare assistant to enable them to carry out these annual health checks.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments of up to 45 minutes and home visits were available where required. All these patients had a named GP and a structured annual review to check that their health and medication needs were 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Although immunisation rates were slightly below the local average for some of the standard childhood immunisations,

Summary of findings

the practice worked proactively to follow up patients who had missed immunisations for all age groups. For example, young people who missed their 15 year HPV booster or who had chosen not to have their booster through their schools. This service was also offered for young women with their course of HPV vaccinations.

Patients and staff 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 joint working with midwives, health visitors and school nurses.

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. For example, extended opening hours were offered on Monday evenings and on weekends before bank holidays.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. For example meningitis C catch up vaccinations for students were offered.

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. Senior partners had a lead role and additional training for care of patients with learning disabilities and offered tailored support to these patients.

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. Clinical staff were trained in vulnerable adult and child safeguarding. They had also received additional training on the mental capacity act which enabled them to deal effectively with the needs of vulnerable patients. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in normal working hours and out of hours.

Summary of findings

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out opportunistic memory screening for patients who may have dementia or concerns about their mental health. At the time of our inspection 13 patients were recorded on the mental health register. The practice had achieved all QOF points for this group. Further assessment and referral for these patients was regularly carried out. All staff had undertaken recent dementia awareness training.

Home visits were carried out for health assessments and medication reviews. Patients were able to self-refer to a local counselling service and advice and signposting was offered to other areas of support.

Summary of findings

What people who use the service say

We looked at the results of the national patient survey from July 2014. 313 patient surveys were sent out and 100 patients returned these which was a 32% completion rate.

The practice performed better than others in the CCG area in relation to the following areas; 75% of patients said it was easy to get through to the practice on the phone (the CCG average was 67%), 86% said the last time they saw a nurse they were good at involving them in decisions about their care (the CCG average was 71%) and 87% said they usually waited 15 minutes or less before their appointment time (the CCG average was 67%). The practice performed less well in the following areas; 80% of patients said the last GP they saw was good at listening to them (the CCG average was 86%), 73% said the last GP they saw or spoke with was good at involving them in decisions (the CCG average was 80%) and 88% said the timing of their last appointment was convenenient (the CCG average was 94%). The leadership team were aware of all of these issues and recognised them as areas for development with plans in place to address all of them proactively.

We spoke with five patients including two members of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them. Members of the PPG told us the practice was well-led and they worked well with the practice to improve the service. All of the patients we spoke with expressed a high level of satisfaction about the way care and treatment was delivered. Patients told us they were involved in decisions about their care and treatment, and clinicians provided adequate information to inform their decision making. They also said they felt listened to and were able to raise concerns with staff if they were unhappy with the care received.

These views aligned with the feedback we received in the 26 Care Quality Commission comment cards that we received. For example, staff were described as being kind, compassionate, caring, pleasant, helpful, polite and attentive. Patients also confirmed they were able to get an appointment when needed in particular same day appointments or telephone consultations. Patients commented on other key areas such as the cleanliness of the practice, that they were treated with dignity and respect and they felt listened to by the staff.

Areas for improvement

Action the service SHOULD take to improve

- Carry out a risk assessment for GPs not carrying emergency medicines in their GP home visit bags.
- Ensure that the practice's whistleblowing policy includes reference to Care Quality Commission (CQC) & NHS England (NHSE) to ensure staff are aware of all agencies they could contact.
- Ensure that all carers are identified on the records system to ensure appropriate information, advice and support for them.
- Carry out appraisals for all staff

Woodside Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission lead Inspector**.** The team included a GP, a practice manager and a second inspector.

Background to Woodside Surgery

Woodside Surgery provides primary medical services to approximately 4400 patients. The practice is situated in the North Nottinghamshire village of Skegby and is part of the NHS Mansfield and Ashfield clinical commissioning group (CCG). The practice population is predominantly white British with a slightly higher than average number of patients aged over 45 when compared with local and national averages.

The practice is based at a single location with services provided over two floors. Services include midwifery, travel vaccines, immunisations and general medical services. The practice has four GP partners, three male and one female, three practice nurses, one healthcare assistant and an administrative support team. The practice also provides a base for community midwives and health visitors.

The practice is open 8:00am to 6:30pm Monday to Friday and offers extended appointments to 7:30pm on Monday evenings for both GP and Practice Nurse.

The practice had opted out of providing out-of-hours services to their own patients. This was provided by Central Nottingham Clinical Services.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. 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.

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

Detailed findings

- 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 held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 11 March 2015. During our visit we spoke with a range of staff (GPs, practice nurses, practice manager, administrative staff) and spoke with patients who used the service. We observed how people were being cared for. We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events was a standing item on the practice meeting agenda and actions from past significant events and complaints were reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Records reviewed showed significant events relating to prescriptions, medicines and communication around hospital transport and appointments were discussed.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked 18 incidents over the past year and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a vaccine fridge was left open accidentally. When it was noticed an incident form was completed and patients contacted and offered repeat vaccination. Two new fridges were purchased to maintain stock levels and an updated system for accessing these fridges was put in place. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager and / or clinical commissioning group (CCG) pharmacist via email and notices to practice staff. We saw that printouts of alerts were placed in staff pigeon holes. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meeting to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. For example, following changes to the recommended dosage of and prescribing guidelines for certain medicines by the Medicines and Products Healthcare Regulatory Agency (MHRA), all patients taking these medicines were reviewed and appropriate changes made to their medicine regime and prescriptions.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed the senior GP as the lead in safeguarding vulnerable adults and children. The majority of clinical staff had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. Following our inspection the practice provided evidence of additional training for the remaining staff. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. Staff were able to give examples of concerns they had raised with the GPs and action taken to address this.

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, children subject to child protection plans.

There was a chaperone policy which was visible on the waiting room noticeboard although we did not see these displayed in consulting rooms, (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Records reviewed showed the following staff had been trained to be a chaperone: one practice nurse, a health care assistant and ten reception staff. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had DBS checks in place and had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

GPs appropriately used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of these children and vulnerable adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

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

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, prescribing within the practice and (MHRA) alerts were discussed and actions noted.

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

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse and practice manager were leads for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. At the time of our inspection, refresher training updates for hand hygiene and infection control update had been scheduled for staff to attend on 25 March 2015. We saw evidence that the lead had carried out an audit in April 2014 and improvements identified for action had been completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Are services safe?

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

The practice had no policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). This did not ensure the risk of infection to staff and patients was minimised. However, plans were in place for an external company to undertake the risk assessment although a date was yet to be confirmed Following our inspection we received evidence from the practice that the assessment had been completed

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included the requirement for all staff to provide proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

The four staff records that we looked at showed that appropriate recruitment checks had been undertaken for most of the staff prior to employment. Where DBS checks had not been undertaken for a GP and administrative staff who undertook chaperone duties, these had been arranged by the end of our inspection. Following our inspection the practice provided evidence that enhanced DBS checks were in place for all staff.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, we saw that the practice manager gave feedback from audits including infection control, complaints and serious incidents.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Records showed that all staff had received training in cardio pulmonary resuscitation (CPR) and the use of a defibrillator. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a non-registered patient and that the practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included

Are services safe?

those for the treatment of cardiac arrest, anaphylaxis (a severe, potentially life-threatening allergic reaction that can develop rapidly) and hypoglycaemia (low blood sugar). The GPs did not routinely carry emergency medicines during home visit. The reason for this was the proximity to Kings Mills Hospital and ease of access to the ambulance service. However, a full risk assessment and a protocol were not in place / documented to demonstrate this had been agreed by the all GPs. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This had been shared with practice staff at the May 2014 meeting. Mitigating actions were recorded for each risk to reduce and manage the risk. Risks identified included loss of utilities such as power failure and gas, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of an electricity company to contact if the electricity system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills, the most recent having been held in January 2015. Fire alarm testing was undertaken weekly.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were discussed. Staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of a range of conditions. Our review of the clinical meeting minutes confirmed that this happened.

We reviewed data from the local Clinical Commissioning Group (CCG) about the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice manager had also completed a review of prescribing data including patterns for prescribing antibiotics and sedatives. The data showed the practice was in line with local and national trends. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw data from the National Cancer Toolkit from Public Health England which confirmed the practice was meeting this target.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients.

The practice informed us of 12 audits that had been undertaken in the last year. We looked at three of these. Two were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of prescribing for patients with asthma showed that the dosage of their medication could be reduced over time if they received regular medicines reviews. This led to improved outcomes for patients and cost savings for the practice. A second audit looked at pre-treatment blood testing and prescribing for patients with foot infections. As a result of the audit all patients received the required pre-treatment blood tests and the amount of medicines initially prescribed were reduced which prevented patients taking medicines when no longer required.

The practice also used the information collected for the Quality and Outcomes Framework QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with heart failure had their diagnosis confirmed by an echo cardiogram, and this practice was performing QOF (and other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

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

Are services effective?

(for example, treatment is effective)

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to or better than other services in the area. For example, referral of newly diagnosed patients with diabetes or heart disease to education programmes.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with sexual and reproductive medicine and accident and emergency (A&E) background. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff had not received annual appraisals that identified learning needs from which action plans were documented.

Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example National Vocational Qualifications NVQs. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. No trainees were present at the time of our inspection.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the administration of vaccines, cervical screening and wound care. Those with extended roles, for example seeing patients with long-term conditions such as asthma, COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

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

There was a system in place to make sure all correspondence and results were read and actioned on the same day. We saw that one member of staff had responsibility for this role and had been involved in developing a protocol for practice staff to follow. The GP who saw these documents and results was responsible for the action required. This was monitored by the staff member by sending a task reminder to the relevant GP via the computer system. All the staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service for hospital discharge monitoring and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, occupational therapist, physiotherapist and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which

gives patients a choice of place, date and time for their first outpatient appointment in a hospital). A designated member of staff was responsible for this. They reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. There was a policy in place in respect of consent to treatment and this highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Practice records showed 60% of care plans for patients with learning disabilities had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, written consent was obtained for all minor surgical procedures such as hormone implants and injections. Records reviewed showed patients signed to confirm the procedure had been explained to them and they gave consent for it to be carried out. Verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We saw that audits of minor surgical procedures had been completed which included a record of patients consent.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registering with the practice. The GP was informed of any health concerns detected and these were followed up in a timely way. We spoke with a GP who said they used their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 150 patients had taken up the offer of a health check. A GP showed us how patients were followed up in a timely manner if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all 15 patients had been offered an annual physical health check. Practice records showed 60% had received a check up in the last 12 months.

The practice had also identified the smoking status of 80% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were overweight, and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 81%, which was in line with the average performance for

Are services effective?

(for example, treatment is effective)

practices in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

Performance for national breast cancer (77%) and bowel cancer (56%) screening in the area were all above average for the CCG (75% and 55%, respectively), and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

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

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015 and a survey of 30 patients undertaken by the practice's patient participation group (PPG). The PPG is 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. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

For example 90% of respondents to the practices own Patient Participation survey found the receptionists very helpful, and 72% of patients felt it was easy to get through to someone at the practice. Overall 82% of patients described their experience at the surgery as very good or excellent and 80% answered 'yes, definitely' when asked 'Would you recommend your GP surgery to someone who has just moved to your local are?'

The practice was slightly below the local average for its satisfaction scores on consultations with doctors and nurses with 80% of practice respondents saying the GP was good at listening to them and 82% saying the GP gave them enough time.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 26 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. However, we saw evidence that staff had received training in customer service and how to deal with difficult situations. Staff told us they valued the training and felt confident to deal with any situations that arose. All staff were aware of how to raise a call for assistance.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey 2014/2015 showed 73% of practice respondents said the GP involved them in care decisions and 85% felt the GP was good at explaining treatment and results. Both these results were above the local CCG averages of 72% and 79% respectively. The results from the practice's own satisfaction survey showed that the overwhelming majority of patients were happy with the care and treatment they received. With 89% of patients saying the GP was good - very good at putting them at ease, being polite and considerate and listening to patients.

Patients we spoke with on the day of our inspection 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

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us they had access to a telephone translation service for patients who did not have English as a first language and could book a British Sign Language Interpreter if required. We saw notices in the reception areas informing patents these services were available.

We saw evidence that patients with long term conditions and those at risk of hospital admission had care plans in place and were supported to complete these by practice staff.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed and patients we spoke with showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received showed that patients were happy with the support they received and access to care.

Notices in the patient waiting room and patient website also signposted people to a number of support groups and organisations, for example, 'Better Together' and 'Let's Talk' aimed at addressing isolation and emotional support. We did not see evidence that patients were identified as carers on the practice computer system. However, staff were able to identify and were aware of patients who were carers and had offered support to them. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. This information was also displayed in the waiting area and on the practice website.

We saw evidence that the practice supported carers and families of patients with additional needs. For example, the partner of a patient, (who was not a patient themselves) attend the practice to discuss concerns regarding the patient confidentially. The issue was dealt with carefully when the patient next attended the practice for a separate appointment and the partner continued to receive pastoral support from the practice nurse and other clinicians.

Staff told us families who had experienced bereavement were supported by the practice and received a welfare call from a GP. Staff told us GP's had visited patients and their relatives in hospital when they were receiving end of life care and following bereavement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, providing winter pressure clinics as part of the Prime Ministers challenge Fund.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, a sit and wait appointment system had been introduced as a result of patient feedback.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example services for those with a learning disability or whose first language was not English. This included longer appointments of up to 45 minutes for completing annual health reviews, and access to online and telephone translation services. The practice had a population of 99% English speaking patients though it could cater for other different languages through translation services.

New patients were able to register either in person or online via the practice website. Information was provided in the practice leaflet and was available in larger print. Online information was available in a number of languages to assist patients who did not have English as their first language. Information was also provided for patients wishing to register temporarily, for example, travellers or patients visiting the area.

The practice provided equality and diversity training through e-learning. Training records reviewed showed four staff had completed this training and plans were in place for additional staff to complete this training.

The practice was situated on the ground and first floor of the building with most services for patients on the ground floor. There was lift access to the first floor. The premises and services had been adapted to meet the needs of patient with disabilities; although at the time of our inspection the automatic front doors were not working.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams, and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice opening times were from 8:00am to 6:30pm and GP appointments were available from 9:30am to 6:30pm pm on weekdays. The practice's extended opening hours on Mondays (6:30pm to 7:30pm) were particularly useful to patients with work commitments and students. The practice opened for three hours on Saturdays if the following Monday was a bank holiday. One patient we spoke with told us they found the extended opening on Mondays useful as they were able to book appointments after finishing work.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments of up to 45 minutes were available for patients with additional needs for example, patients with long term conditions, older people, patients with and people experiencing poor mental health. Patients with learning disabilities had access to extended appointments and a range of supportive resources to allow them to be as involved as possible with their care and decision making. Two partners had attended additional training to help

Are services responsive to people's needs?

(for example, to feedback?)

them meet the needs of patients with learning disabilities. Staff at the practice ensured patients had access to the service and treatment they needed at all times. For example, during a period of bad weather, the practice nurse identified patients who required dressings changed but may be at risk of fall and arranged home visits to change their dressings and reduce the risk of falling.

Patients were generally satisfied with the appointments system. They told us they had experienced difficulty in the past using the telephone booking system but this had improved after feedback to the practice. We saw evidence that the appointment system had been discussed at practice meetings. Patients confirmed that they could see a GP on the same day if they needed to, although not always the GP of their choice. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment on the day of our inspection. They had been offered two time slots on the same day and were able to see the GP of their choice.

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 saw that information was available to help patients understand the complaints system including a complaints leaflet, information in the practice information leaflet, a poster in the waiting area and information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint, however none had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way. The practice had carried out a review of complaints received in the past 12 months both written and verbally. Although no overarching themes or trends were detected, we saw that lessons learned from individual complaints had been acted on and we saw evidence of shared learning amongst staff. For example, a patient raised a complaint after they experienced a delay in accessing a hospital appointment which resulted in a delay of diagnosis for their illness. The practice involved the patient in the investigation of the complaint and identified changes required to their processes. As a result of the patient's involvement and the open attitude of the practice, the issue was resolved to the patient's satisfaction.

Are services well-led?

(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. This included: taking a holistic and person centred approach to patient care; practising traditional family medicine in a relaxed and friendly atmosphere as well as treating patients with dignity and respect. We spoke with 12 members of staff and they all knew and understood the vision and values, and what their responsibilities were in relation to these. The practice leadership told us they were in the process of formalising their business plan which included areas such as succession planning and alternative premises to cater for the growing practice population.

We found all staff had agreed to uphold the practice values in their interactions with patients. This included treating patients with compassion, maintaining their confidentiality, being non-judgemental and a commitment to ensuring consistency in the delivery of services. We looked at the meeting minutes for 25 February 2015 and saw that staff had discussed and agreed that the values were still current. The vision and practice values were also included in the patient practice guide and website to promote awareness amongst the patients. These values were also displayed in the waiting areas and in the staff room.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 11 of these policies and procedures. All 11 policies and procedures we looked at had been reviewed at least annually and were up to date. At the time of our inspection the practice did not have a system in place to record that staff had read and understood the policies. However we saw evidence that this would be recorded in a new staff handbook that was under development.

There was a clear leadership structure with named members of staff in lead roles. For example, we saw that the practice nurse and practice manager were joint leads for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing at or above average when compared with local and national standards. We saw that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes. For example, the practice had identified that patients with asthma and diabetes were reluctant to attend for reviews so had developed an action plan to address this issue, including personal invitations to attend the practice and discussing the need for review at routine appointments.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit was undertaken to review asthma medication in patients with a high dose of inhaled medicines and the resulting outcome was that their medication was reduced where appropriate in line with the Nottinghamshire adult asthma guidelines.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example fire risk assessments.

The practice held monthly business meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example health and safety safeguarding, chaperone and recruitment which were in place to support staff. All policies were detailed and showed evidence of recent review. Staff we spoke with knew where to find these policies if required.

Are services well-led?

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, the family and friends test and complaints received. We looked at the results of the family and friends test for December 2014 and January 2015. Thirty-six responses had been received and 69.44% of respondents would recommend the practice to friends and family. We saw that an action plan had been agreed for areas identified as needing improvement. For example, looking at a better queuing system for patients when patients ring the surgery.

The 2013/14 practice patient showed 89% of respondents felt the GP was good - very good at putting patients ease, being polite and considerate and listening to patients. Of the 30 patients surveyed 90% of patients had 'confidence that the GP is honest and trustworthy' and 90% of those surveyed answered yes to 'would you be completely happy to see this GP'.

Alongside the PPG The practice had a virtual patient participation group (VPPG). The PPG included representatives from older people and working population groups. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. Access to appointments, patients not attending booked appointments and promotion of the role and membership of the PPG were highlighted as areas for inclusion in the survey action plan. We saw that at all stages of the survey and action plan the practice had sought to involve the PPG.

The practice had gathered feedback from staff through staff away days and generally through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff had all been involved in developing the practice's promise and values which included the six C's. The six C's referred to: care, compassion, commitment, confidentiality, community and consistency. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. The policy did not include contact details for the Care Quality Commission and NHS England for staff to report to.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had staff protected learning days where guest speakers and trainers attended. However, we found that due to staff absence no appraisals had been completed for non-clinical staff within the last 12 months as stipulated in the practice policy. The practice manager showed us the updated schedule for staff appraisals. This indicated that all staff would receive annual appraisals and included an induction and review schedule for new staff.

The practice was a GP training practice and a teaching practice for medical and nursing students. At the time of our inspection there was one student nurse on placement. They told us they had a supportive and positive learning experience and highlighted how well organised and structured the placement had been. For example the practice had offered support in gaining experience for a course assignment