Saxon Cross Surgery

Quality Report

Saxon Cross Surgery
Stapleford Care Centre
Church Street
Stapleford
Nottingham
NG9 8DA
Tel: 0115 9392444
Website: www.saxoncrosssurgery.co.uk

Date of inspection visit: 29 September 2015
Date of publication: 07/01/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Saxon Cross Surgery on 29 September 2015. Overall the practice is rated as good.

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

- There was a clear leadership structure and staff felt supported by management.
- High standards were promoted and owned by an enthusiastic and motivated practice team with evidence of highly effective team working.
- The practice had excellent facilities and was well equipped to treat patients and meet their needs.
- Results from the national GP survey, and responses to our conversations with patients, showed that patients were treated with compassion, dignity and respect, and that they were involved in their care and decisions about their treatment.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. We found evidence of learning being applied from incidents to enhance future service delivery. People affected by significant events received a sincere apology and were told about the actions taken to improve care.
- High quality patient care was paramount to what the practice did. Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff training was up to date and individual staff were supported to continually develop in their roles – for example, a nurse had commenced training to become the second advanced nurse practitioner (ANP) within the practice. An ANP would be able to see a broader range of patients and have a greater degree of autonomy to make decisions.
- Risks to patients were assessed and well managed. Regular liaison meetings were held with the wider multi-disciplinary team to co-ordinate the delivery of effective and responsive care.
- We saw excellent examples that demonstrated the practice's commitment to working with the Clinical

Summary of findings

Commissioning Group (CCG), other GP practices in Nottinghamshire, and local health and social care providers to achieve the best outcomes for patients and share best practice.

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). For example, the PPG organised a session to raise awareness of dementia, leading to some practice staff being awarded 'Dementia Friends' status.

We saw several areas of outstanding practice including:

- The practice proactively used data to review their performance and to make changes to continuously improve outcomes for patient care. For example, by analysingunplanned hospital admissions to provide additional support, such as referral to community and voluntary services, that would enable patients to remain in their home.
- A GP partner had led on the implementation of a shared intranet system across local CCGs to facilitate learning by the sharing of data and access to a range of documents including best practice guidance. This innovation had led to the introduction of a performance tool called eHealthscope which had been rolled out to all practices across Nottinghamshire.
- Opportunities for learning from incidents were maximised by working collaboratively with the Clinical Commissioning Group (CCG), other GP practices, and community and secondary care service providers.
- The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced patient attendance at A&E compared against the national average, and also by positive patient survey results. This flexibility was facilitated by a good skill mix which included an advanced nurse practitioner (ANP) who led a triage service. A practice nurse had been supported to maintain her skills from a previous role by seeing patients with minor injuries to assist access and help relieve pressure on GP appointments. There were three independent nurse prescribers in the practice offering greater flexibility in offering patient consultations.
- Nurses rotated on a weekly basis to be assigned to a different doctor to discuss patients and access mentorship. This facilitated a thorough understanding of working with each other and helped to share expertise across the practice.
- Management of end of life care was planned effectively in conjunction with the multi-disciplinary team and this had resulted in only 18% of patient deaths in hospitals in the last year. This was a significant improvement to the previous 12 months in which 42% of the practice's end of life patients had died in hospital. This reflected the achievement of the practice and community based teams to engage in difficult conversations with patients, families and carers to respect the patient's wishes.
- The practice held a daily meeting for clinicians to discuss challenging cases and referrals. This meeting was observed during our inspection and was observed to be an effective approach in supporting the team, sharing ideas and focussing on patient care.

However, there were areas of practice where the provider should make improvements:

- The practice had attempted to obtain information on the environmental risks overseen by the landlord on a number of occasions with limited success, but should negotiate a more formal mechanism to discuss and record the premise related issues which impact directly upon the practice.
- The practice policy for chaperones should outline a clear procedure for acting as a chaperone and reflect recent guidance for where the chaperone should stand during the examination
- The practice should complete the infection control audit action plan from March 2014 and ensure all clinical rooms are included within any future infection control audit

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.

The practice used every opportunity to learn from internal and external incidents and implement measures to minimise any recurrence. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed, and shared outside of the practice when appropriate to ensure wider learning took place. Risks to patients were assessed thoroughly and well managed.

There were sufficient numbers of qualified and trained staff to meet patients' needs and keep them safe. Staff had been appointed designated lead areas of responsibility to oversee internal processes and act as a resource for the practice team. Robust and effective systems were in place for the management of medicines. The practice had safeguarding procedures in place and staff had undertaken training to help protect children and vulnerable adults from the risk of harm. Infection prevention and control systems were in place and staff had access to suitable and well maintained equipment.

The practice should implement a more formal process to document site-related issues and to gain its own assurances on the quality and outcomes of the site-led systems, risk assessments and audits, and the resulting actions which impacted upon the practice. For example, in relation to fire and legionella.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.

The practice had achieved 100% of the available points as part of the Quality and Outcomes Framework (QOF) in 2013-14 and the practice's own data for 2014-15 demonstrated this had been maintained. Data showed that the practice was consistently performing highly when compared to neighbouring practices in the Clinical Commissioning Group.

The practice used innovative and proactive methods to improve patient outcomes such as a reduction in the number of hospital admissions, and it worked collaboratively with other local providers to enhance best practice. This had resulted in positive outcomes for

Summary of findings

patients as demonstrated by lower urgent hospital admissions. For example, unplanned hospital admissions for patients with a long-term condition were 66.75 per 1000 patients compared with a national average of 89.78.

The practice reviewed its own performance through a defined audit programme, which led to demonstrable improvements for patients, for example in relation to the quality of end of life care.

All staff had received an annual appraisal and personal development plans had been produced for each employee. Staff had received training appropriate to their roles and any further training needs had been identified, and the practice supported their team to receive the necessary training. The system of support and mentorship was both robust and effective and the practice maximised the skills and abilities of the whole team in delivering effective patient care.

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 almost all aspects of care. Feedback from patients about their care and treatment was consistently positive. We observed a patient-centred culture. Results from the national GP surgery demonstrated that the practice scored higher than CCG and England averages for all questions relating to care and being treated with respect. For example, 93% of patients who responded to the survey said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.

Staff were motivated and inspired to offer kind and compassionate care, for example staff had received training to become 'dementia friends'.

We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. For example, 93% of patients who responded to the national GP survey said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.

There was a proactive approach to the identification of carers and directing them to sources of support. Bereaved relatives were visited by the GP responsible for their loved-one's end of life care to offer condolences and provide any additional support that might be required.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice implemented a late evening surgery once a week in response to patient feedback on the most preferred option for extended hours' provision. Access to appointments was valued by patients and 91% of patients who responded to the national GP survey described their experience of making an appointment as good compared to the CCG average of 82% and national average of 73%. Patients told us it was relatively easy to get an appointment with a GP of their choice. There was continuity of care and urgent appointments available on the same day. We observed that routine appointments could be booked within a few days. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG) such as the introduction of a screen providing information for patients in the waiting area. The practice reviewed the needs of its local population and engaged with other practices and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. The practice had piloted initiatives including participation in a community urology and pain clinic to help reduce elective (planned) referrals to hospital.

The practice had excellent facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Outstanding ☆

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. The leadership team were forward thinking and innovative, looking for ways to improve the service for their own patients and those across the local area. The practice was proactively engaged with their CCG and had been instrumental to pilot new ways of working to adapt to the increasing demands from primary care services. There was a clear leadership structure and staff felt supported by management. GPs had lead areas of responsibility, and roles including the Advanced Nurse Practitioner had been introduced to facilitate greater efficiency. Staff engaged with networking opportunities to share best practice and work collaboratively on ventures. The practice had a comprehensive range 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

Summary of findings

feedback from patients, and it had an active patient participation group (PPG) which influenced practice development. All the practice team had received inductions, structured appraisals, 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

Outstanding ☆

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

Data showed the practice performed well in caring for their older patients. For example, 100% patients aged 75 or over with a fragility fracture (this is a fracture caused by low level impact, which would normally be counteracted by strong bone density) since April 2012 were being treated with an appropriate medication, compared against the national figure of 81.27%. There was also an emphasis on preventing ill health as demonstrated by influenza vaccinations for patients over 65 which was 80.68% for 2013-14, compared to 75.3% in the CCG, and 73.24% nationally.

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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with an urgent need. Patients could book longer appointments in recognition of the multiple and complex problems associated with ageing. Annual health checks were undertaken for patients over 75 years old. The practice worked hard to avoid unplanned hospital admissions, but where these had occurred, individual circumstances were reviewed to support patients to stay in their home.

The practice has registered with Age UK to offer support to its older patients.

The siting of the practice within Stapleford Care Centre provided patients with easy access to other services located in the building including phlebotomy, the psycho-geriatrician and the Citizen's Advice Bureau.Older patients with the highest risk of hospital admission were proactively managed in conjunction with the local health community team including the Crisis Intervention Service and community health care older people specialist, and organisations such as the Helpful Bureau to help patients stay in their own homes. The practice worked effectively with other providers to manage end-of-life care with compassion and dignity.

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, which had kept emergency admissions for patients with long term

conditions low. Data demonstrated that the 2014 figure for unplanned hospital admissions for patients with a long-term condition was 66.75 per 1000 patients compared with a national average of 89.78. Longer appointments and home visits were available when needed. All these patients had a named GP 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 Advanced Nurse Practitioner (ANP) provided initiation of insulin (teaching patients how to inject and manage their insulin regime) for type 2 diabetes (type 2 diabetes occurs when the body doesn't produce enough insulin to function properly). The ANP did a monthly joint clinic with the diabetic nurse specialist to review more complex diabetic patients.

The practice referred patients with long-term conditions who suffered anxiety for specialist support through the Improving Access to Psychological Therapies (IAPT) programme.

The practice website contained details on long term conditions including symptoms; treatment and self-management advice; and links to other resources and support available for each condition.

We spoke with some patients during the visit with a long-term condition and they all commented about how positive their experience had been when visiting the practice.

Families, children and young people

Good

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

The practice had a higher than average percentage of patients aged 0-4 years (7.1% compared to 6.0% nationally), and were responsive to their needs, for example in terms of achieving high immunisation rates for children under five years of age. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

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. The nurse-led triage system ensured rapid access to care for sick children. Appointments were available outside of school hours and the premises had appropriate facilities for children and babies. There were established communication links to promote joint working with midwives, health visitors and

school nurses. The siting of the practice within the care centre supported access and linkages to contraception and sexually transmitted infection screening services for teenagers, and baby and hearing test clinics for infants.

Working age people (including those recently retired and students)

Good

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This had been facilitated by a nurse-led triage system. The practice opened until 8.30pm one evening per week, and patients could book appointments up to four weeks ahead. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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. It had carried out annual health checks for people with a learning disability and achieved 43% in 2013-4. Figures for 2014-5 were reduced to 28% and the practice had recognised this as an area for improvement. The practice have met with the CCG learning disabilities co-ordinator to improve engagement by offering greater flexibility in appointments, sending invites by a telephone call rather than by letter, making a follow up call as a reminder the day prior to the scheduled review.

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, and had received training in domestic abuse. 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 – for example, Framework for homeless people (a charitable organisation that supports the homeless). The practice had social care representation in their local care team to ensure a more holistic approach to care.

Summary of findings

The practice were proactive in recognising and signposting carers of vulnerable patients to access the care they needed. Patients had access to interpreter services (including signing experts) if required.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

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

In 2014-5, 97% of patients on the practice mental health register had a documented care plan in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Members of the practice team had been awarded 'Dementia Friends' status, giving them a better understanding on the impact of dementia, and the ability to signpost to effective support services for patients and carers. A 'Dementia Friends' awareness session has been organised at the practice by the Patient Participation Group (PPG) in conjunction with the local council in 2014.

The practice 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.

Staff demonstrated an understanding of how to apply the principles of the Mental Capacity Act to ensure those patients who lacked capacity to make decisions themselves received treatment according to their best interests.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing above local and national averages in terms of patient experience. There were 117 responses to the 286 distributed surveys which represented a 41% response rate of patients who received the survey.

The practice scored higher than average in terms of patient experience with regards to making an appointment, ease in booking that appointment via the telephone, and also in regard to accessing a preferred GP. For example:

- 96% find it easy to get through to this surgery by phone compared with a CCG average of 85% and a national average of 73%.
- 91% describe their experience of making an appointment as good compared with a CCG average of 82% and a national average of 73%.
- 75% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 66% and a national average of 60%.

The survey identified the practice could perform better in the following areas:

- 57% respondents usually wait 15 minutes or less after their appointment time to be seen, compared to the CCG average of 66%, and a national average of 65%
- 54% patients feel they don't normally have to wait too long to be seen, compared to CCG average of 61% and National Average of 58%

The practice were aware of the comments regarding waiting times and were actively seeking to address this issue, without compromising patient care in having to rush consultations

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards which were very positive about the standard of care received. Key themes included helpful polite staff, ease of access to appointments and a clean environment.

Saxon Cross Surgery

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 second CQC inspector, a practice manager specialist adviser and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Saxon Cross Surgery

Saxon Cross Surgery is located within Stapleford Care Centre in a residential area in Nottinghamshire. It provides primary medical services to its 7,301 registered patients. The practice is situated on the upper ground floor of the care centre building and is co-located with a range of community based services and another GP practice. There are a higher proportion of children under 5 years of age, and a slightly higher percentage of older people on the patient list compared with other practices in England. The majority of patients are of white British background.

The practice has five part time GP partners (three male and two female). It is a training practice for GPs in that GP Registrars work at the practice. A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. They usually spend at least two years working in a hospital before joining a practice and are closely supervised by a senior GP as their trainer.

The practice has an Advanced Nurse Practitioner (this is a highly skilled qualified nurse with greater autonomy to see patients and make decisions without the GP's input) and three part-time practice nurses. The clinical team are supported by a full time practice manager, a health care assistant and reception and administration staff.

The practice is open between 8.00am- 6.30pm Monday to Wednesday and Friday, and from 8.00am-1.00pm and 4.00pm-6.30pm on Thursday, with an extended hours' surgery available every Tuesday until 8.30pm. Appointments are from 8.30am to 11.20am every Tuesday to Friday morning (on Mondays, appointments are available from 8.40am to 11.30 am). Afternoon appointments can be booked from 3.40pm (4.00pm on a Thursday) to 6.00pm every afternoon, and on a Tuesday until 8.30pm.

Every Thursday afternoon between1.00pm-4.00pm, and during the evenings and weekends, an out-of-hours service is provided for patients by Nottingham Emergency Medical Services (NEMS) via the 111 service.

The practice offers a range of enhanced services (that is services provided above those included within their core contract) including minor surgery.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

Detailed findings

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. The only exception to this is the childhood immunisation rates which apply to 2014-15.

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 our inspection, 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 inspection on 29 September 2015. During our inspection we spoke with staff including GPs, practice nurses, the practice manager and a number of reception and administrative staff. In addition, we spoke with health professionals outside of the practice regarding their experience of working with the practice team; this included a health visitor and a CCG pharmacist. We also spoke with patients who used the service, and a representative of the practice patient participation group. We observed how people were dealt with during their visit to the practice. We reviewed 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. We saw evidence of ten significant events being recorded over the last 12 months, which included both clinical and non-clinical incidents. People affected by significant events received a timely and sincere apology and were told about the actions taken to improve care. Staff told us they would inform the practice manager of any incidents and they would complete the template in order for the information to be input onto practice's computer system. The practice reviewed significant events on an ongoing basis at clinical and staff meetings but did not routinely undertake an annual analysis of their significant events to detect themes or trends.

We reviewed safety records, reports and minutes of meetings where these were discussed. We saw that lessons were shared to make sure action was taken to improve safety in the practice. For example, a patient had been prescribed a medication which was inappropriate for their condition. The patient came to no harm and received an apology, but the practice ensured that all staff were alerted of the need for vigilance in checking any medication warning alerts that appear on their consultation screen alongside the necessity to review the patient's past medical history.

Additionally, we saw that the practice had been proactive in identifying learning for other organisations and sharing this with them. For example, we saw a case in which a patient had a missed diagnosis despite being seen by several hospital departments. The practice contacted the hospital to suggest the event being reviewed collaboratively. The practice had hosted an event for other local practices as part of a CCG initiative to jointly review significant events and to share learning across the area. Each practice submitted three significant events for discussion. For example, this practice shared an event in which a problem had been highlighted with their software provider in the transmission of results from the pathology laboratory. This highlighted the issue to others who used the same computer system, and helped them to apply the learning which had already been achieved from the incident.

The practice had systems in place to ensure that safety information received externally was disseminated within the practice. Information was received by the practice manager and disseminated to the relevant staff, and also logged into a register in addition to being printed and filed for future reference. Examples of information received included patient safety alerts and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). We saw that the practice had dealt with a recent MHRA alert (August 2015) on mobile blood glucose meters which could give inaccurate readings if the manufacturer's instructions were not fully adhered to, creating a false low reading indicating a requirement for insulin. The practice had actioned this by reviewing all their diabetic patients to check if they used this meter, and were able to re-assure themselves that none of their patients used this particular equipment.

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 accessible to all staff. The practice policy identified a named GP as the lead for safeguarding children and vulnerable adults. We spoke with a health visitor who informed us that the practice always shared concerns regarding vulnerable children promptly and communication between them was regular and informative. The safeguarding policy outlined what staff should do if they had concerns about the welfare of a patient and documented contact details of external agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role, including Level 3 training for all GPs.
- A notice was displayed in the consulting room advising patients that a chaperone could be made available for intimate examinations, if required. All staff who acted as chaperones received training for the role, and those currently acting as a chaperone had completed 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). The practice policy for chaperones did not detail a clear procedure for acting as a chaperone nor did it reflect recent guidance for where the chaperone should stand during the examination.

- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy available. The practice had an up to date fire risk assessment and regular fire drills were carried out. All electrical equipment had been checked in August 2015 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 manual handling, display screen equipment and lone working. However, the responsibility for environmental risk assessments lay with the site management and the practice had not sought comprehensive assurance that the assessments were adequate. Therefore the practice could not be assured they were fully informed of any actions being taken as a result of risk assessments.
- High standards of cleanliness and hygiene were observed. We found the practice to be well-maintained and tidy. The advanced nurse practitioner was the infection control clinical lead and she liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control policy in place and staff had received up to date training. The landlord undertook regular cleaning audits to ensure high standards of cleanliness throughout the practice. The practice had undertaken an infection control audit in August 2015 although this did not incorporate all the clinical rooms, and it was not evident that all of the identified actions from the previous infection control audit in March 2014 had been completed. For example, in relation to the clinical and non-clinical waste bins being pedal operated.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy team to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored.
- The practice recruitment policy documented the recruitment checks required prior to a staff member commencing employment. 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 and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

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 and there were emergency medicines available in the treatment room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also 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. This identified risks to normal operation of the practice such as being unable to access the building, power failure or an issue with the telephone systems. Copies of the plan were held by all members of staff (either as a hard copy or electronically) and the practice's buddy practice. The plan included emergency contact numbers for staff and suppliers.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patient care and treatment was delivered in line with recognised best practice standards and guidelines including the National Institute for Health and Care Excellence (NICE), and local pathways of care. Staff told us that information and any changes in legislation or national guidelines were shared during regular clinical staff meetings, and we saw evidence that this was happening routinely.

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. The most recently published results demonstrated that the practice had achieved 100% of the total number of points available in 2013-14. This practice was not an outlier for any QOF (or other national) clinical targets and had an exception reporting rate of 8.9%, which was 1.4% higher than the CCG and 1% higher than the England averages. The exception reporting figure is the number of patients excluded from the overall calculation due to factors such as non-engagement when recalled by the practice for reviews. A lower figure demonstrates a proactive approach by the practice to engage their patients with regular monitoring to manage their conditions. QOF data from 2013-14 showed;

- The practice had achieved 100% of points available for diabetes related indicators which was better than the CCG average of 95.3% and national average of 90.1%
- The practice had achieved 100% of points available for hypertension indicators compared to a CCG average of 86.3% and a national average of 88.4%

Pre-inspection information available to us indicated that the practice had a lower rate in identifying patients with depression in comparison to the CCG average. However, the practice were able to explain this in that they ensured patients were fully assessed to determine a definitive diagnosis of depression. Therefore, they were able to identify those presenting with forms of anxiety rather than depression and treat them via the most effective care pathway.

Clinical audits were carried out to drive quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been five practice clinical audits completed in the last year, and some of these were completed audits where the improvements made were implemented and monitored. For example, as a result of an audit on Methotrexate in 2014 (Methotrexate is used in the treatment of rheumatoid arthritis to limit inflammation which helps to reduce signs and symptoms of the disease such as pain and swelling), recommendations were made to improve the requirement for patients to have quarterly repeat blood tests as part of a safe prescribing monitoring regime. The original audit demonstrated this was being achieved in 63% of patients. However, following the implementation of recommendations after the initial audit, the follow-up audit in March 2015 showed their achievement had improved to a figure of 96%.

The practice also participated in applicable local audits including four prescribing audits undertaken as part of the CCG's prescribing incentive scheme. Feedback from the CCG pharmacist was that the practice engaged well with them and that they were very responsive to suggestions for improvements. They provided an example where the practice reduced the prescribing of cephalosporins and quinolones (antibiotic drugs) to 3.04% compared against a national average of 5.21%.

Information about patients' outcomes was used to make improvements. For example, patients who had been admitted to hospital as an unplanned admission were reviewed by the clinical team to consider anything that could have been done differently to have avoided this admission, and this was used for wider learning across the practice. This had impacted on outcomes for patients with long term conditions in that the 2014 figure for unplanned hospital admissions was 66.75 per 1000 patients compared with a national average of 89.78.

Effective staffing

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

Good

Are services effective?

(for example, treatment is effective)

- GPs had lead roles, for example in diabetes and dermatology, and acted as a resource for other members of the team to share best practice. Internal referrals were encouraged to ensure that patients with a complex need saw the most appropriate GP.
- The practice actively developed staff and a second nurse was undergoing training to become an Advanced Nurse Practitioner. Three of the nurses were able to prescribe and two nurses offered a minor illness/injuries service for patients. GPs actively mentored the nurses on a rotational basis. The practice supported medical registrar placements and had recently recruited a new partner who had undertaken their registrar training with them. Apprentice placements were available to join the reception team.
- The practice had an induction programme for newly appointed members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. We saw evidence of induction programmes and signed copies of their completion in staff files
- 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 one-to-one meetings, mentoring, clinical supervision and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. We spoke with staff who confirmed that they received training and were supported to do so. Staff were given the option to undertake on-line training outside of work and claim time back for this. The practice did not keep a central record of all staff training which meant it was difficult for the practice manager to have oversight of all of the training needs. Whilst staff training was fully documented for non-clinical staff, there was an onus on clinicians to keep records of their own training. We saw that the individual clinicians had undertaken the appropriate training for their role, and were encouraged to develop their skills. For example, one nurse was looking to commence a diploma in asthma management with the support of the practice.

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 plans, medical records and test results. 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. For example, older patients with the highest risk of hospital admission were proactively managed in conjunction with the local health community team to help patients stay in their own homes. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Management of end of life care was planned effectively in conjunction with the multi-disciplinary team and this had resulted in only 18% of patient deaths in hospitals in the last year. This was a significant improvement to the previous 12 months in which 42% of the practice's end of life patients had died in hospital. This reflected the achievement of the practice and community based teams to engage in difficult conversations with patients, families and carers to respect the patient's wishes.

The practice held a daily meeting to discuss challenging cases and referrals. This meeting was observed by our GP Specialist Adviser who commented this was a big commitment for the clinicians, but was a very effective approach in supporting the team, sharing ideas and focussing on patient care.

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

Good

Are services effective?

(for example, treatment is effective)

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, those at risk of developing a long-term condition and those requiring advice on their smoking and alcohol cessation. The practice scored very highly in signposting patients to smoking cessation advice (96.5 per 1,000 population compared to the CCG average of 91).

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 86.03%, which was above the CCG average of 81.88% and the national average of 77.08%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. For example, there was a 60% uptake of bowel screening compared to a national average of 56% and the practice planned to introduce a computerised register of screening failures to improve further uptake.

Childhood immunisation rates for the vaccinations given were almost all above the CCG averages for 2014-15. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 89.9% to 98.3% and five year olds from 82.4% to 98.6%. Flu vaccination rates for the over 65s were 80.68% compared to a national figure of 73.24%, and at risk groups 63.29% compared to a national figure of 52.29%.

Patients had access to appropriate health assessments and checks. These included offering health checks for all 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

During the inspection, we saw that staff were helpful and polite towards patients both in the reception area and on the telephone. 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 and there was a sign displayed in reception to inform patients of this.

The 11 patient CQC comment cards we received were 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. Patients also told us they were satisfied with the care and treatment they received and that they felt listened to during consultation. Comment cards and feedback from patients highlighted that staff responded compassionately when they needed help.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 93% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.
- 94% patients said they found the receptionists at the practice helpful compared to the CCG average of 91% 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 and results were in line with local and national averages. For example:

- 94% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 90% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 81%
- 92% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%

We saw notices in the reception areas informing patients that translation services were available should these be required. There was also a facility on the practice's website which enabled translation of the text into a number of different languages.

Patient and carer support to cope emotionally with care and treatment

A range of information was available in the waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer, and there was a practice register of all people who were carers. An identified practice carer's champion

Good

Are services caring?

attended quarterly CCG meetings and this has led to updates on information and literature being made available for carers to ensure they understood the range of support available to them.

Staff told us that if families had experienced bereavement, a GP would arrange to visit within two or three days. This would usually be the GP who had been primarily involved in the care of the patient. Family members were offered the appropriate support or signposted to external organisations who could offer support.

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 CCG to plan services and to improve outcomes for patients in the area. The CCG had undertaken a mystery-shopper exercise to provide assurances on appointment availability and the most recent one had taken place in March 2015. This showed that the practice achieved 85% in delivering a GP appointment within the 72 hour period.

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;

- Extended hours appointments were available every Tuesday evening. The practice had asked patients for their preference as to whether an evening or Saturday morning session would be more beneficial to them, and patients had said that the later evening opening was their preferred option.
- There were longer appointments available for people including those with a learning disability, and older people who presented with complex issues.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities including disabled parking and ramped access from street level as the practice is situated on an upper ground floor. A hearing loop was available for patients who were hard of hearing.
- The practice had acted on patient feedback –for example, it provided some high back chairs in reception for those patients who struggled to get out of a low seat.
- Facilities were offered for baby changing and the reception area had a pushchair parking area.
- A sign in the reception area advised patients that they could access translation services if required. Signing services were also available and practice leaflets were available in larger font sizes.

Access to the service

The practice opened between 8.00am and 6.30pm Monday to Friday, but was closed on Thursday between 1.00pm-4.00pm when the practice had protected learning time.

Appointments were available from 8.30am-11.20am daily (Mondays 8.40am-11.30am) and 3.40pm-6.00pm daily (Thursday 4-6.00pm). Extended hours surgeries were offered every Tuesday evening from 6.30-8.30pm.

The nurse practitioner led a triage system for all patients wishing to be seen urgently on the day so that GPs were able to prioritise time for the patients with the greatest clinical need. The nurse practitioner also led a minor illness service which allowed the best use of the GP's consultation time. This created capacity which enabled the practice to offer a GP appointment within 72 hours, and we saw evidence of this on our inspection. Pre-bookable appointments could be booked up to four weeks in advance.

A weekly report was generated by the practice to assess demand and some GPs would provide additional clinical sessions to accommodate patients. Historically, the practice did not use locum GPs, but one was working at the practice during our inspection. This locum was being used to cover a GP's paternity leave to ensure ongoing good access for their patients. We were informed that one GP was developing data software to assist with rota planning.

We viewed data which demonstrated the rate of attendance at Accident & Emergency (A&E) for practice patients was 255.1 per thousand practice population compared to a national average of 328.72, and this indicated that the measures employed by the practice to increase access had helped reduce A&E attendance.

During the inspection, patients told us they were very satisfied with their experience in obtaining an appointment at the practice. Results from the national GP patient survey reinforced patient's satisfaction with how they could access care and treatment which was above local and national averages. For example:

- 96% patients said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 73%.
- 91% patients described their experience of making an appointment as good compared to the CCG average of 82% and national average of 73%.

However, 57% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%. Feedback from patients we spoke with during the inspection was that the usual waiting time was between 15 and 20 minutes and

Good

Are services responsive to people's needs?

(for example, to feedback?)

that the longest wait had been 30 minutes. However, patients told us they were happy to wait and understood that the practice was busy. They said they were kept informed of any delays by the reception team.

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 there was information available for patients about the complaints process. However, this was not prominently displayed within the waiting area and could not easily be seen from the seating area. Patients we spoke with were not aware of the complaints procedure but felt that they could complain if they needed to. Complaints forms were available for patients from the reception area if these were required. The forms outlined the complaints procedures.

We looked at 14 complaints received in the last 12 months and found these were satisfactorily handled, dealt with openness and transparency, and responded to in a timely manner. Patients received an apology where this was appropriate. We observed that some information regarding complaints was recorded on the patient's record, although this should be documented separately. We explained this to the practice which acknowledged this issue and agreed to implement this immediately.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, the practice had reviewed the way in which it dealt with travel advice when patients required advice and inoculations at short notice.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement and staff knew and understood the practice values. The partners had a demonstrable commitment to improving the health of their own patients as well as that of the wider community and this showed in the way the practice shared innovative practices and learning.

Governance arrangements

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

- There was a robust staffing structure and staff were clear about their role and individual responsibilities, and understood how this contributed to the overall aims and aspirations of the service.
- Practice specific policies were implemented and were available to all staff
- There was a comprehensive understanding of the performance of the practice through proactive engagement with the CCG and the use of eHealthscope. This system allows viewing and analysis of information to deliver good patient care.
- A programme of continuous clinical and internal audit was used to monitor quality and to drive improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions
- Regular meetings were held with staff to ensure information was cascaded in a timely manner, and to provide an opportunity to discuss any concerns which may have arisen.

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. The practice was actively involved in CCG work-streams and one GP sat on the CCG Board and took lead responsibility for areas including information technology and cancer. The practice manager chaired the CCG wide practice manager's forum and the ANP engaged with other nurses across the CCG area.

Staff told us that full team meetings took place every six to eight weeks, and that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt supported to do this. Staff said they felt respected and valued by 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. There was a low turnover of staff and individuals we spoke to were proud to work for the practice and portrayed great enthusiasm for their work. The practice were fully aware of how the workforce needed to adapt to meet the demands of general practice and were proactive in their approach to succession planning, as demonstrated by the training of a second ANP and recruitment of a new GP partner.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through internal surveys (most recently in March 2015) and a suggestion box, and from analysis of complaints. There was an active PPG which met on a regular basis, carried out patient surveys and made suggestions for improvements to the practice management team. For example, the PPG had been involved in the introduction of a television screen in the waiting area. The screen announced appointments and also offered health promotion information.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and told us they felt involved and engaged to improve how the practice was run.

The practice received a four-and-a-half star rating (out of 5) on the NHS Choices website. There had been four comments left by patients in the last 12 months of which

Are services well-led?

Outstanding ☆

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

three were extremely positive about the patient experience. Feedback received from the Family and Friends Survey demonstrated patients would be happy to recommend the practice to others.

Innovation

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

The practice benefited from the information technology expertise provided by one of the GP partners who proactively used data to review and improve services for patients. The GP had been instrumental in developing a shared intranet facility for clinicians and commissioners across the county of Nottinghamshire called eHealthscope. This facilitated benchmarking across local practices, including those in some neighbouring CCGs, and gave access to a range of information, guidance, performance and outcomes.

Data was analysed to review the outcomes being achieved, and then consideration was given to how actions could be taken to improve future performance, an example of this being reviewing individual GP referral rates and reflecting on different ways some of those with the highest referral rates might have been managed.

The practice was actively involved in developmental projects and part of local pilot schemes to improve outcomes for patients in the area. For example, they are participating in a community urology and pain clinic to help reduce elective (planned) referrals to hospital.

Succession Planning was being considered at every level in the practice, including non-clinical staff. The practice has developed an Apprentice Receptionist Scheme with two other practices and CCG approval. This involved a local employment agency providing NVQ support to the apprentices across the scheme. The aim is that other local practices will become involved as they see positive outcomes achieved from this scheme and promote the locality as one that offers employment and career opportunities to young people in their local communities.