Saxon Cross Surgery

Quality Report

Stapleford Care Centre
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Date of inspection visit: 14/11/2017
Date of publication: 12/04/2018

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Outstanding overall.
(Previous inspection 29/09/2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Outstanding

People with long-term conditions – Outstanding

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced inspection at Saxon Cross Surgery on 14 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- At our last inspection, we found that a GP partner had led on the implementation of eHealthscope, a shared intranet system across the local CCG to facilitate learning by the sharing of data and access to a range of documents including best practice guidance. This innovation had led to eHealthscope being rolled out to all practices across Nottinghamshire. At this inspection, we found the practice had continued to develop this system to review and improve patient care by creating information sharing platforms with other practices and healthcare providers.
- The practice used information about care and treatment to make improvements. For example, they initiated opportunistic pulse rhythm checks to

Summary of findings

improve their identification of people with atrial fibrillation, resulting in 78% of eligible people having checks for the condition and two people being diagnosed with the condition.

- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Staff had the skills, knowledge and experience to carry out their roles. Mentorship of the nursing staff was shared amongst all GPs in the practice, enabling them to learn different skills from the clinicians.
- The practice understood the needs of its population and tailored services in response to those needs. Patients were able to access care and treatment from the practice within an acceptable timescale for their needs through a variety of methods.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. This included the sharing of policies, significant events and clinical audits with other practices within the CCG using the shared eHealthscope system and practice group meetings. As a result, some practices implemented the audits and adopted the same approach to improving the quality of care across the whole CCG.

We saw some areas of outstanding practice:

- The practice continued to promote innovation by developing a workflow system within the eHealthscope which enabled holistic care of registered patients with complex needs by identifying community teams that were involved or needed to be involved in their care.
- Clinicians initiated opportunistic pulse rhythm checks to improve their identification of people with atrial fibrillation, resulting in 78% of eligible people over 64 years old having checks for the condition and two people being diagnosed with the condition.
- Leaders at all levels were visible within the practice as well as the CCG where they held various positions, enabling them to influence improvements across the group of practices. Mentorship for the nursing team was rotated amongst all the GP partners to share skills and build resilience within the team.

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

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

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 advisor and a practice nurse specialist advisor.

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, commissioned by NHS England and NHS Nottingham West CCG. 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.

Public Health England data shows 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 GP partners (three male and two female) and one salaried GP. It is a training practice for GP Registrars who 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 setting before joining a GP 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 four part-time practice nurses, two of whom are prescribers. 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 8am- 6.30pm from Monday to Friday. Extended opening hours are offered every Tuesday from 6.30pm to 8.30pm with two GPs available. Appointments are available from 8.05am to 5.50pm, with emergency appointments added at the end of clinics. 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.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice used a range of information to identify risks and improve patient safety. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). We looked at three recruitment files and found that all the appropriate checks had been carried out.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The advanced nurse practitioner was the nominated lead who took responsibility for ensuring actions from audits were completed.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. A rota system was used for all staff and cover arrangements were made if any staff were absent. The GPs worked flexibly to cover annual leave absences internally.
- There was an effective induction system for temporary staff tailored to their role, including locum doctors.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. We saw examples of completed sepsis management templates on their clinical system.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

Good

Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- The practice worked closely with a pharmacist employed by their CCG to support clinical safety. The pharmacist ran regular audits on prescribing and communicated any changes in guidance with the clinicians. Feedback from the pharmacist was positive about the responsiveness of the clinicians in acting on any recommendations given.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- There was a system in place for monitoring patients on high risk medicines. The advanced nurse practitioner led on reviewing patients and there were alerts on the relevant medical records used to act as reminders to aid monitoring.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Significant events were recorded on the eHealthscope, an information system developed by a GP at the practice which was used as a shared intranet to share learning across all practices within their CCG. Additionally, other practices could upload their significant events and any relevant ones were discussed within the practice as a learning opportunity as part of sharing best practice.
- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as outstanding for providing effective services overall and long term conditions and older people population groups.

The practice was rated as outstanding for providing effective services because:

- The practice used the eHealthscope information system to pioneer a workflow system for detecting patients with long term conditions who should be receiving support from other specialist teams such as pulmonary rehabilitation, chronic obstructive pulmonary disease (COPD) and heart failure. Subsequently, they were high users of these community services.
- Complex cases were discussed on a daily basis, giving clinicians opportunities for second opinions before making referrals. The practice used eHealthscope; a unique feature within the system was to enable the capturing of clinical reasons for referrals made outside of the e-referrals system across all the practices who used this tool.
- The practice developed their own frailty tool to aid in assessment and review of those identified as being frail and at risk of admission, who were referred to appropriate support via the care coordinator. People considered to be frail received telephone calls upon discharge from hospital to ensure they had adequate support in place to prevent re-admission. This contributed to the lower than average emergency admission rates (88 per 1000 patients compared to the national average of 97 per 1000 patients).
- The practice recognised they had low incidence of atrial fibrillation, which could be a result of not identifying patients with the condition. In response to this, they used their flu clinics to identify patients over 64 years old who may have atrial fibrillation by offering pulse rhythm checks during the clinics. At the time of our inspection, they had checked 78% of eligible patients and two people had been found to have the condition.
- An audit of bowel screening rates carried out by the practice was adopted by some practices within the CCG and influenced proactive approaches to improving screening uptake rates across the whole group.
- Mentorship of the nursing staff was rotated amongst all GPs in the practice, enabling them to learn different skills from the clinicians.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- For example, the practice rates of prescribing of hypnotics and antibiotics were comparable to other practices.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Complex cases were discussed on a daily basis, giving clinicians opportunities for second opinions before making referrals. The practice used eHealthscope; a unique feature within the system was to enable the capturing of clinical reasons for referrals made outside of the e-referrals system across all the practices who used this tool.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. They maintained a 28 day multi-disciplinary team (MDT) cycle which ensured all patients where the team was involved were reviewed monthly and not missed. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 98.5% and national average of 95.6%. The overall exception reporting rate was 9% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good

practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice developed their own frailty tool to aid in assessment and review of those identified as being frail and at risk of admission, who were referred to appropriate support via the care coordinator.
- The practice recognised they had low incidence of atrial fibrillation, which could be a result of not identifying patients with the condition. In response to this, they used their flu clinics to identify patients over 64 years old who may have atrial fibrillation by offering pulse rhythm checks during the clinics. At the time of our inspection, they had checked 78% of eligible patients and two people had been found to have the condition.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice used the eHealthscope information system to pioneer a workflow system for detecting patients with long term conditions who should be receiving support from other specialist teams such as pulmonary rehabilitation, chronic obstructive pulmonary disease (COPD) and heart failure. Subsequently, they were high users of these community services.
- Performance on indicators related to COPD was 100%, in line with the CCG average of 99% and above the national average of 96%.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- People with diabetes were reviewed annually for monitoring. This included women who developed gestational diabetes during pregnancy. Staff told us the practice had a high rate of referrals to the national diabetes prevention scheme.
- Overall performance indicators related to diabetes was 100%, compared to the CCG average of 98% and the national average of 91%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Immunisation rates for children up to age 2 were 99%, which was significantly higher than the national target of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. A midwife worked with the practice to provide ante-natal and post-natal care to patients.

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

- The practice's uptake for cervical screening in 2015/16 was 83%, which was in line with the 81% coverage target for the national screening programme.
- Breast and bowel screening rates were in line with local averages. The practice actively encouraged eligible patients to return home test kits sent out to them for bowel screening to improve uptake. An audit of bowel screening rates carried out by the practice was adopted by some practices within the CCG and influenced proactive approaches to improving screening uptake rates across the whole group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74.
- There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People on the learning disabilities register were offered annual health checks. Staff told us people with learning disabilities were offered longer appointments and these were scheduled during quiet times in the surgery to ensure they were seen promptly.
- People considered to be frail received telephone calls upon discharge from hospital to ensure they had adequate support in place to prevent re-admission. This contributed to the lower than average emergency admission rates (88 per 1000 patients compared to the national average of 97 per 1000 patients).

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

- Overall performance on mental health indicators was 100%, 4% above the local average and 6% above the national average.
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months, 6% lower than the national average.
- Self referrals to local psychotherapy and counselling services were encouraged for patients with less urgent needs.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- Mentorship of the nursing staff was rotated amongst all GPs in the practice, enabling them to learn different skills from the clinicians.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. There were scheduled weekly telephone calls between one GP and the community care coordinator to facilitate decision making over patients with complex problems.
- The practice used the workflow register in eHealthscope which allowed daily updates from GPs, community teams and secondary care on individual patients identified as being at high risk of hospital admissions. They were able to identify any gaps in care, for example, a patient with severe COPD who is not under the care of the community COPD team, and ensure they were referred appropriately.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- Staff encouraged and supported patients to be involved in monitoring and managing their health. Patients were able to self-refer to psychotherapy and smoking cessation services.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- Patients were encouraged to attend local support groups, for example, friendship groups, carers drop in clinics and support groups for carers of people with cancer.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity and NHS health checks for people aged 40 to 74.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Most of the patient Care Quality Commission comment cards we received (41 out of 45) were positive about the service experienced, and described being treated respectfully by the practice team. This is in line with other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 258 surveys were sent out and 118 were returned. This represented about 1.6% of the practice population. The practice was above average in some areas for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 91% of patients who responded said the GP gave them enough time; CCG - 89%; national average - 86%.
- 94% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 83% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 88%; national average - 86%.
- 93% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 89% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 97% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful; CCG - 90%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers, including young carers, opportunistically and at registration with the practice. The practice's computer system alerted GPs if a patient was also a carer.

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. Carers were offered flu vaccinations and annual health checks.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or offered a home visit. Referrals to bereavement services were made where appropriate.

Good

Are services caring?

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

- 89% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 83% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 84%; national average - 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 88% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 90%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. For example, plans were at an advanced stage to change the practice clinical system to enable other healthcare teams to view and share their records; thereby providing a holistic approach when treating patients.

- The practice understood the needs of its population and tailored services in response to those needs.
- We found translation services were available for patients who did not have English as a first language through a telephone interpreting system called language line. Signing services were also available and practice leaflets were available in larger font sizes.
- A telephone triage service was operated all day and there were same day appointments available.
- Additional services such as ECGs, spirometry and 24 hour ambulatory blood pressure checks were offered in house. Travel vaccinations were offered on site.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- 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 in the practice for people who may need it.
- Facilities were offered for baby changing and the reception area had a pushchair parking area.

Older people:

- The practice was aware of an increasing elderly population in their community. All patients had a named GP who supported them in.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- All patients over 75 years old who were frail had care plans in place. The practice worked with a care coordinator to ensure those with complex needs had reviews when discharged from hospital.

People with long-term conditions:

- The nursing team held clinics for chronic disease management. Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- Additionally, the nurses used these clinics to carry out opportunistic pulse rhythm checks to identify people who may have atrial fibrillation. At the time of our inspection, they had checked 78% of eligible patients and two people had been found to have the condition.
- Community healthcare teams such as heart failure nurses and a diabetic specialist nurse held regular clinics at the practice to support the management of patients with complex long term conditions.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice had a significant proportion of children on their list, compared to national averages. We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The practice held regular meetings with family health practitioners (formerly known as health visitors) and midwives to ensure coordinated care. Both practitioner groups held regular clinics in the same building as the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- All parents or guardians calling with concerns about a child under the age of two years old were offered a same day appointment when necessary. This was supported by feedback from patients we spoke to at the inspection.

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

- The needs of this population group 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 on Tuesday evenings until 8.30pm with two clinicians.
- Appointments with GPs and phlebotomy services started from 8.05am. These could be booked online, by telephone or in person. Additionally, there was a nurse triage system operated all day for telephone advice, and 18 GP telephone appointments daily.
- NHS checks were offered for 40-74 year olds.
- There were plans underway within the CCG to offer extended opening hours in the local area in the evenings and at weekends seven days a week in 2018 to accommodate working people.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Staff were aware of vulnerable patients and prioritised their access when necessary.
- Self-referral was encouraged for services such as counselling and drug and alcohol services for those who needed them.
- The practice recognised people's social needs and worked with citizens advice bureau and social services teams based in the same building as the practice.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice referred eligible patients to local psychotherapy services and memory groups for people with dementia.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. The practice was open between 8am- 6.30pm from Monday to Friday, and from 8am-1pm. Extended opening hours were offered every Tuesday from 6.30pm to 8.30pm with two GPs available. Appointment slots started from 8.05am to 5.50pm, with emergency appointments added at the end of clinics.
- Waiting times, delays and cancellations were minimal and managed appropriately. Patients with the most urgent needs had their care and treatment prioritised. A telephone triage service was operated by the advanced nurse practitioner, who assessed patients with urgent needs over the telephone and offered them appointments where necessary. An additional clinician assisted with the triage service during busy times. This was following findings of an audit of waiting times for returning calls to patients using the telephone triage service. A repeat of the audit showed significant reduction in waiting times especially on busy days of the week due to the additional staff on the service.
- Patients were offered a variety of choices. In addition to same day appointments, routine appointments with a GP could be booked up to four weeks in advance, with pre-bookable telephone appointments available. Online appointment bookings were encouraged.
- GPs worked a varied number of sessions every week. This allowed them to work flexibly in response to demand and to be available at short notice when required. The partners told us they were satisfied with this approach and it led to improved patient satisfaction.
- The practice participated in the CCG's 'Engaged Practice Scheme', which included a quarterly review of their access through a mystery Shopper exercise. Under this exercise, practices were required to offer 60% of calls a routine appointment with any GP within five working days. Results from the exercise published in April 2017 showed the practice was able to consistently provide

Good

Are services responsive to people's needs?

(for example, to feedback?)

routine GP appointments within three days for over a year. On the day of the inspection we found that the next routine GP appointment was available within two days.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mostly above local averages. This was supported by some observations on the day of inspection and completed comment cards.

- 80% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 83% and the national average of 76%.
- 92% of patients who responded said they could get through easily to the practice by phone; CCG – 88%; national average - 71%.
- 91% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 90%; national average - 84%.
- 89% of patients who responded said their last appointment was convenient; CCG - 89%; national average - 81%.
- 85% of patients who responded described their experience of making an appointment as good; CCG - 84%; national average - 73%.
- 52% of patients who responded said they don't normally have to wait too long to be seen; CCG - 60%; national average - 58%.

The practice participated in the CCG annual patient survey, whose results in 2017 showed 14% of the patients who responded (total 331 responses) said they booked appointments online, thereby relieving some pressure on the telephones. The practice reviewed results from both the local and national surveys, and agreed an action plan to improve patient satisfaction. This included installing IT software which enabled them to monitor their telephone call volumes and the speed of answering calls. Alerts were added onto records for patients whose needs required double GP appointments. This led to a reduction in waiting times to be seen by a clinician. The number of staff on the telephone triage service were increased to three for the first hour on Mondays to assist with the higher volume of calls.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice had received five complaints, both verbal and written, in the 12 months prior to our inspection. We reviewed the complaint records and found that it was satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. Complaints were discussed at team meetings and some were reviewed as significant events. It acted as a result to improve the quality of care.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice as outstanding for providing a well-led service.

The practice was rated as outstanding for providing a well-led service because:

- Since our last inspection, the practice continued to proactively use data to review and improve services for patients. This was achieved through the continued development of the eHealthscope, a shared intranet facility for clinicians and commissioners across the county of Nottinghamshire. The system was used to share policies and procedures, significant events, clinical audits and referrals.
- Leaders at all levels were visible within the practice as well as the CCG where they held various positions, enabling them to influence improvements across the group of practices. Mentorship for the nursing team was rotated amongst all the GP partners to share skills and build resilience within the team.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. In addition, some GPs had senior roles within their CCG and the greater Nottingham CCGs. The advanced nurse practitioner coordinated the local practice nursing forum.
- The practice manager chaired the local practice manager forum meetings which were held on a monthly basis for peer support and development of managers in their CCG. The forum was also used for coordinating future working plans in line with CCG and NHS England strategies and sharing best practice in management.
- 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.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, they were aware of challenges with limited car parking spaces available at the site, and worked with the local authorities and other services in the building in promoting the use of alternative parking arrangements.

Vision and strategy

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

- There was a clear vision and set of values. Staff told us they were motivated by making a positive difference to people's lives by educating them to manage their health and wellbeing whilst providing high quality services.
- The practice had a realistic strategy and supporting business plans to achieve priorities. The practice manager met with the partners regularly to discuss performance, workforce and contingency planning in line with their strategy.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. For example, they worked closely with their CCG and other practices on providing evening and weekend GP services in the near future to meet the needs of the practice population.
- The practice monitored progress against delivery of its strategy.

Culture

Are services well-led?

Outstanding ☆

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

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. For example, following feedback about low staff morale, the partners held a 'question and answer' meeting with all staff to encourage openness and better interaction across all staff groups.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Mentorship for the nursing team was rotated amongst all the GP partners.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- The practice created an advanced action log and issues log which recorded actions from all meetings held in the practice to ensure a cohesive approach, accountability and transparency within the practice.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. Each partner led on a specific key area.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There was a comprehensive understanding of the performance of the practice through proactive engagement with the CCG and the use of the eHealthscope information system. There was continued development and proactive use of the system by the practice which allows viewing and analysis of information to deliver good patient care.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. The practice took a further step by sharing their significant events with other practices within their CCG to ensure learning was shared to avoid recurrence in other practices.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. There were

Are services well-led?

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eight full cycle clinical audits undertaken in the last two years. Audits could be shared via the eHealthscope information system to allow other practices to learn from their findings.

- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG) with eight members who met monthly, and their meetings were attended by a member of the practice team. Since our last inspection, the PPG had set up a virtual PPG group with ten members. A noticeboard dedicated to the PPG was displayed in the waiting area with information on how to join the group. Additionally, the group advertised in local newspapers and churches to increase their membership. The chair of the group was involved in a clinical development group set up by the CCG's patient reference group, and participated in other CCG activities such as the mystery shopper exercise for patient experience.
- The PPG reviewed patient feedback from surveys, a suggestion box and the NHS friends and family test, and discussed actions to improve patient experience. Feedback from the group was positive about the management of the practice and their willingness to adopt suggestions by the group.
- An annual newsletter was produced by the practice and used to inform patients of health events, staff changes and news relating to the next year. The PPG told us they contributed to articles in the newsletter.
- The service was transparent, collaborative and open with stakeholders about performance. They worked closely with other practices in their area to establish joint policies and procedures across the CCG as well as sharing learning from significant events and audits by having a shared platform where each practice could upload and view these.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. Training doctors participated in a number of clinical audits.
- There was continued development and use of the eHealthscope system within the practice to run the practice more efficiently and achieve better outcomes for patients. This included the sharing of policies and procedures, clinical audits and referral information with other practices within the CCG. For example, audits of bowel screening and over-prescribing of tramadol (a

Are services well-led?

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strong pain medicine used to treat moderate to severe pain) were adopted by some practices within the CCG and influenced proactive approaches to improving screening uptake rates across the whole group.

- The service was a training practice for qualified doctors who wanted to become GPs, some of whom remained to work at the practice after completing their training course.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.