Tillingham Medical Centre

Inspection report

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

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	**Good** ●
Are services effective?	**Outstanding** ☆
Are services caring?	**Outstanding** ☆
Are services responsive?	**Outstanding** ☆
Are services well-led?	**Outstanding** ☆

Overall summary

This practice is rated as outstanding overall. (This is the first inspection of Tillingham Medical Centre)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Outstanding

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? – Outstanding

We carried out an announced comprehensive inspection at Tillingham Medical Centre on 13 April 2018. This inspection was carried out as part of our inspection programme.

This was an outstanding practice that was consistently achieving high outcomes. There were many areas of outstanding practice, but the ones we wish to highlight are:

- The practice had developed a strong and positive culture for staff and patients. There was a clear commitment to staff wellbeing, holistic patient treatment and focused collaboration with external stakeholders. The practice provided the highest level of support to enable all staff to provide care to their patients. They encouraged staff training and innovative developments to facilitate staff in achieving their shared vision of high quality care for patients. The leadership strategies in place had been developed with the input of staff, patients and external stakeholders and had resulted in high achievements for patient outcomes.
- The practice could evidence a strong commitment to national priorities and preventative care for patients. For example, the practice had developed and implemented a system whereby if a patient was registered as a carer and admitted to hospital, the practice made contact with the person the patient cared for. This was to ensure an appropriate care package was in place if required and that medicines were being managed effectively. External agencies were contacted if required to ensure the patients' needs were met.
- The practice had part funded a primary care matron, after a successful pilot in collaboration with the local community provider. The primary care matron role included visiting patients that had been discharged from hospital to safeguard against any potential future admissions. The role also included joint assessments with external agencies to ensure a fully holistic approach to the management of patients with complex healthcare requirements. The primary care matron also implemented 'rescue plans' for vulnerable patients to meet social issues that may have otherwise been undetected. Feedback from external agencies and patients regarding this role was wholly positive and the practice could demonstrate they were the second lowest for unplanned admissions to hospital in the clinical commissioning group.
- The practice had planned, implemented and monitored innovative and creative methods of treating patients with learning disabilities. For example, the practice had worked in close collaboration with the local home for patients with learning disabilities to create a visual pain scale for patients to use. They ensured a high level of continuity of care for these patients and had worked to build a rapport. Where patients wished to attend the practice, reception ensured appointments were given at a suitable time and often offered patients the last appointment of the day to ensure the environment was calm.

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

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector and a GP specialist adviser.

Background to Tillingham Medical Centre

- The registered provider for the service is the Dengie Medical Partnership.
- The practice web site is www.dengiemedicalpartnership.nhs.net.
- The provider provides services for patients at two locations; Tillingham Medical Centre, 61 South Street, Tillingham, CM0 7TH and at a branch surgery; Maylandsea Medical Centre, Imperial Avenue, Maylandsea, CM3 6AH. We did not visit Maylandsea medical centre on this inspection.
- Tillingham Medical Centre provides services under a General medical service contract with NHS England to their 4850 registered patients.
- The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.
- The practice population is in the third least deprived decile in England. The practice population of children is slightly lower than national and mid Essex clinical commissioning group (CCG). The population group for older people is slightly higher than national and the CCG.
- Whenever the surgery is closed patients can call the usual telephone number, and they will be transferred to GP out-of-hours service NHS 111 who will ascertain the most appropriate course of action.
- The practice team is made up of two partners and a regular locum GP; a nurse practitioner, a primary care matron, practice nurses and a health care assistant. Administration support included a practice manager and reception and dispensary manager who were supported by several non-clinical personnel.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- Safeguarding adults, children and young people at risk was given high priority. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, and responded proactively to any signs or allegations of abuse, working collaboratively with others.
- All staff received up-to-date safeguarding and safety training appropriate to their role. All GPs, nursing staff and the primary care matron were trained to safeguarding level three. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) We saw detailed examples of safeguarding discussions, including potential and emerging concerns, such as children's referrals into mental health services. There was effective coding in patient records allowing for easy identification and cross-referencing.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. The practice held bi-monthly meetings with the safeguarding team and social services to discuss all patients on the safeguarding register. They took this opportunity to reconcile lists to ensure that all patients on the list were captured and appropriately monitored.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. Electrical and calibration testing was carried out on an annual basis. There were systems for safely managing healthcare waste.

Risks to patients

A proactive approach to anticipating and managing risks to patients was well embedded.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- The practice had difficulty in recruiting an additional GP, therefore they performed a workload audit in order to continually assess the number and mix of staff to meet patient needs. This audit looked to identify presenting symptoms and assess whether they were referred to the most suitable clinician. The result of the first audit was that the practice identified they should increase nursing appointments to free up some GP appointments. Part of this audit included a breakdown of the reason for consultations. As a result of this, the practice employed a heath care assistant and placed two nurses on prescribing courses to increase their scope of practice. The second audit showed an increase in the appropriateness of clinicians seeing certain conditions. For example, the primary care matron had spent 30% of time doing blood tests in the first audit. This had reduced to 10% in the second audit. There was a plan to continue to do this audit in order to continue to make the appointments system efficient and ensure patients are seen by the most appropriate clinician.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. There were emergency medicines and equipment at the practice.
- 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 including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety, for example with the workload audit.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was available

to staff. There was a documented approach to managing test results and hospital correspondence. We saw that all results were cleared within 24 hours of coming in to the practice.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The practice regularly invited external colleagues to the practice for multidisciplinary team reviews. Where these could not be attended, the practice ensured that they had communication with the teams, such as physiotherapists and social services.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The practice were in line with local and national averages for prescribing.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. The system to monitor patients on high-risk medicines was effective. Patients were involved in regular reviews of their medicines. Patients commented positively on how involved with their care and treatment they were. There were several pieces of feedback from external teams commenting positively on the practices' management of patient's medicines.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice had a good track record on safety.

- 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 of safety that led to safety improvements.
- There was an overall risk log which identified all risks in the practice from all risk assessments. This was reviewed in the managers meetings to continually assess and update any ongoing risks.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Staff we spoke to reported there was a positive culture for reporting significant events and near misses.
- 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. The practice, where appropriate, completed a root cause analysis to fully understand why events had happened and to stop them re-occurring.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. Medicines alerts came in to the lead GP and dispensing manager. These members of staff discussed what actions were required to be taken and by whom. These actions were all recorded and completed.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services effective?

We rated the practice and all of the population groups as outstanding for providing effective services, except families children and young people, people with long term conditions and working age people which we rated as good. We rated effective as outstanding because:

The practice structured their care to ensure it met the needs of the population. For example, outcomes for the quality and outcomes framework were consistently high over the past three years. The practice fully considered the needs of each patient, for example the practice would often do 'observational' health checks of patients with severe mental health issues where clinically appropriate to reduce the stress and burden on patients. Staff were given and encouraged to take opportunities for development and there was a strong ethos to upskill staff within the practice. The practice worked closely with other healthcare professionals and often carried out joint sessions in order to fully offer holistic care and treatment for patients.

(Please note: Any Quality Outcomes (QOF) data relates to 2016/17. QOF is a system intended to improve the quality of general practice and reward good practice.*)*

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that there was a truly holistic approach when clinicians assessed needs and delivered care. Treatment was given in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged, for example the use of a primary care matron to improve outcomes for patients.
- We saw no evidence of discrimination when making care and treatment decisions in the records we viewed.
- The practice utilised an online repeat prescription service to increase patient's self-management of their medicines.
- Staff used appropriate tools to assess the level of pain in patients. For example, the practice utilised pictorial charts for assessing pain in patients with learning disabilities. This method had been discussed with the local home that supported patients with a learning disability and with their carers.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people. This population group was rated as outstanding because:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. These patients were all discussed at bi-monthly meetings with the wider multi-disciplinary team to ensure the appropriate and accurate care plan was in place to best support their care needs.
- 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. The practice was proactive with social prescribing and had strong lines of open communication with local support and charity groups.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The primary care matron ensured that all patients discharged from hospital had a home visit within 48 hours of their discharge to update their care plan and tailor any services required to their needs where possible. Where this was not possible, for example where the matron was on leave, a phone call was completed and a visit completed at a later date. The matron used this as a chance to review the reason for admission and put actions in place to prevent the admission happening again.
- All patients under the care of the primary care matron had her direct contact details. These were kept in patient's homes. Paramedics often used these when attending patient's homes where the patient did not immediately require a hospital admission and could be managed in the community. This had reduced unplanned admissions to hospitals as direct and early contact with the matron often resulted in the issue being managed at home. For example, this inclusive approach to treatment including the practice, external

Are services effective?

agencies and the patient had aided the practice in having the second lowest unplanned admissions to accident and emergency in the clinical commissioning group.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. There was a low turnover of staff within the practice which facilitated strong relationships with patients and continuity of care.

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.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. For example, nurses had training in respiratory conditions and diabetes management.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. There was a system in place to review the out of hours admissions daily and contact each patient. The practice tried, where possible, to offer appointments and put plans in place to reduce out of hours calls.
- The practice had arrangements for adults with newly diagnosed cardiovascular disease including the offer of high-intensity statins for secondary prevention, people with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice were in line with most local and national averages for nationally reported outcomes relating to long term conditions. The practice was slightly higher than average for exception reporting for patients with atrial fibrillation due to an automatic coding issue. The notes we reviewed showed a good level of care for these patients and appropriate exception reporting. The practice had completed a full review of all of these patients and put a system in place to ensure the correct coding of these patients was implemented. This system was due to be reviewed on an ongoing and regular basis.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90%. If patients did not attend childhood immunisation appointments, they were proactively followed up by nurses and offered another appointment at a date and time to suit them.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice offered joint six week post-natal and baby checks to reduce the amount of appointments required for new mothers.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 78%, which was in line with the 80% coverage target for the national screening programme.
- The practices' uptake for breast and bowel cancer screening was in line with the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. There was a dedicated notice board in reception to inform patients of which vaccines were required before attending university. When patients attended for these vaccines, the nurses used this as a chance to give patients sexual health advice. There were also chlamydia testing kits in the toilets for patients to access.
- 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.

Outstanding ☆

Are services effective?

People whose circumstances make them vulnerable. This population group was rated as outstanding because:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice held bi-monthly meetings with the hospice team to ensure that medicines that may be required at the end of life were prescribed in a timely and efficient manner for patients.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice had completed 100% of the health checks for patients with a learning disability. The practice had worked hard to build a rapport with patients with a learning disability and ensured care plans were personalised. For example, some patients became very distressed by having blood tests or monitoring, so the practice ensured there was continuity of care with the same visiting clinician to build and maintain trust. Where it was felt not clinically necessary to have blood tests, the practice completed observational reviews of patients.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia). This population group was rated as outstanding because:

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- The practice was aware that their national reported performance for mental health was 7% below the local average and 9% below the national average. The practice supported a local home for patients with severe mental health diagnoses and many of these patients were not appropriate for full health checks. The practice did not exception report these patients, but did complete observational health checks in order to assess and manage their patients appropriately. The overall exception reporting rate for mental health was 4% which was significantly below the local average of 14% and the national average of 11%.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. Patients were also signposted to appropriate support groups or referred to the local mental health teams.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.

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. All staff were aware of and engaged in activities to monitor and improve care. Where appropriate, clinicians took part in local and national improvement initiatives. Outcomes for people who use services were positive, consistent and generally exceeded expectations. For example:

- The practice had identified that urine samples were being sent without a clinical reason being recorded in the notes. The first audit showed poor coding of patients with a urinary tract infection, high use of antibiotics and slow uptake of the use of urine dipsticks. As a result, the practice increased training on appropriate symptoms to take a urine sample and also identification of when a urine dipstick would be more appropriate as the primary test, rather than sending a urine sample. The practice then ran a second audit which showed an improvement in coding, reduction of antibiotics prescribed, an increased in urine dipstick procedure use as a first line of assessment and a reduction of inappropriate urine samples being sent for investigation.
- The practice had achieved high outcomes for the Quality Outcomes Framework (QOF) for the past three years, which also included exception reporting being either in line or below local and national averages. The

practice discussed their outcomes regularly in clinical meetings as a way of driving improvement throughout the year. Staff at all levels were involved in achieving the high results and there was a clear culture of driving improvement in QOF.

- The practice used information about care and treatment to make improvements and to continue to sustain high levels of performance.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had noted that a matron post would improve the care they could give to patients. The local community provider had funded this post for a year. Due to the high impact and positive feedback from external partners regarding the role, the practice had decided to part fund this, alongside the community provider to continue to offer this service and high level of care for patients.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. The continuing development of the staff's skills, competence and knowledge was recognised as being integral to ensuring high-quality care by the management team. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice. The practice supported staff to go on update courses to ensure their skills were in line with best practice guidance.
- 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. Staff were able to give comprehensive and accurate information regarding recent updates.
- 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. Staff were positive regarding the training opportunities that were available. For example, the practice had fully supported two nurses to undertake their prescribing courses. Staff reported that the culture for learning and improvement was positive throughout the practice.
- 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. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. Staff reported that appraisals were personalised and supported their learning needs.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

Staff were committed to working collaboratively 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 and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice held monthly multidisciplinary team meetings, attended by the hospice team, a health navigator, district nurses and any other local teams that were required. For example, the primary care matron reviewed the list of patients due to be discussed and then invited any relevant teams such as social services or the physiotherapist team. There were ongoing and open lines of positive communication with the external teams to the practice and feedback from these teams was wholly positive regarding the practice.
- Any patients discussed in this meeting that required follow-ups were proactively managed to ensure the appropriate care was being delivered in a timely manner. The care plans were viewed were comprehensive and updated on a regular, bi-monthly basis.

Are services effective?

- When the matron referred patients to the community based teams, such as physiotherapists or social services, the practice ensured that a joint assessment was completed with these teams. This ensured that appropriate hand over of medical information was carried out and that the practice were actively involved in the holistic management of patients with more complex needs. This had resulted in positive relationships being built between the practice and external teams, and that patients were fully involved in all stages of their care.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for people with long term conditions and when coordinating healthcare for care home residents. The shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- 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. There was a system in place to review and triage all discharge letters from hospital. Where an admission was not routine and where it was possible, patients received a home visit within 48 hours of discharge. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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. These patients were discussed with the local hospice team to ensure best practice support was adhered to.

Helping patients to live healthier lives

Staff were consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of ill-health, and they used every contact with people to do so.

- 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. Where a carer was admitted to hospital, the practice visited the cared for person to ensure they could continue to be managed in the home environment. Referrals to other services were made as a priority for these patients to maintain independence and keep them at home while their carer was in hospital.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes and 'health hubs' which were used to educate patients on conditions prevalent in the practice population and promote proactive management of conditions.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

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.
- The practice supported a home for patients with learning disabilities. These patients had their mental capacity assessed on a regular and ongoing basis and the practice worked closely with the home to support best interest decisions and advanced care planning. These decisions were fully documented in patient's care plans. Feedback from the home was wholly positive as to the engagement and working relationship with the practice.
- Clinicians supported patients to make decisions.
- The practice monitored the process for seeking consent appropriately.
- The practice gained written consent for minor surgery and for clinical photography (for example, for wounds).

Please refer to the Evidence Tables for further information.

Are services caring?

We rated the practice as outstanding for caring because:

The practice were significantly above local and national averages for several indicators on the GP Patient Survey relating to the caring service the practice provided. Patients reported they were truly respected and valued as individuals and were empowered as partners in their care. This view was reflected by several external stakeholders who commented on the positive working relationship and strong caring culture within the practice. There were several examples of individualised care where the practice had adapted their services and appointments to create bespoke treatment plans, reflective of patient requests.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treated people. People reported that staff the extra mile and their care and support exceeded their expectations. We viewed several pieces of feedback from external stakeholders which commented on the positive culture and caring nature of staff.
- Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. For example, the team supported joint visits for patients with other members of the multidisciplinary team to fully assess and address social needs.
- Staff reported, and we saw, a strong person-centred approach to care. Staff were motivated and inspired to offer care that was kind and promoted people's dignity. Staff were able to give specific examples of personalised care. For example, staff would often call patients that had not attended the practice for a period of time to check their welfare. Any concerns were appropriately escalated. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. There was a strong culture of multidisciplinary working in order to gain the best outcomes for patients.
- The practice gave patients timely support and information.
- All results on the national GP patient survey were in line or above average for outcomes relating to kindness, respect and compassion. We received 42 comment cards which were wholly positive about the care received at the practice. Comments related to the professionalism and care received and that patients never felt rushed during appointments. Patients reported that they felt a part of their care.
- Many staff had worked in the practice a number of years. As a result, there was a good rapport with patients, which was reflected in the positive comments.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. People who used services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. The practice supported a home for patients with learning disabilities. The practice ensured that easy read materials were always available, or that information was explained to patients and carers in a way that was suitable for them. The practice reported it was important for all patients to feel involved in their care.
- Staff always empowered people who used the service to have a voice and to realise their potential. For example. The practice worked closely with the patients and staff in a local home for patients with learning disabilities. The practice had implemented specific materials to ensure patients were partners in their care and could make informed decisions. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care was delivered. For example, the practice took into account the stressful nature of some health checks for patients with mental health conditions. Where it was not deemed clinically necessary, the practice completed observational health checks. This had increased the trust and rapport patients had in the clinicians and allowed them to make decisions about their care.

Are services caring?

- Examples were given whereby patients did not want to attend the normal appointment schedule for treatments such as vaccines. The practice had therefore formulated a bespoke appointment schedule for certain patients to meet both their needs, and ensure this complied appropriately with the vaccine schedule.
- Staff recognised that people need to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensured that people's communication needs were understood and they helped them ask questions about their care and treatment.
- Outcomes from the national GP patient survey were consistently above average for involvement in care and treatment. This was reflected in what patients told us on the day.
- The practice proactively identified carers and supported them. They offered carers flu jabs and signposted them to the local health hub for support. Where appropriate, the matron also referred carers to support groups. There was a prompt on the clinical system to alert clinicians and non-clinical staff that the patient was a carer to enhance the care offered at every stage. When a patient being cared for passed away, the practice had a range of support methods in place. For example, they often visited the bereaved patient or phoned them. If the practice were unable to get in contact with the patient, they sent a personalised letter to the carer offering an appointment, support and signposting to local services.

Privacy and dignity

People were always treated with dignity by all those involved in their care, treatment and support. Consideration of people's privacy and dignity was consistently embedded in everything that staff did, including awareness of any specific needs.

- 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.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this. Staff found innovative ways to enable people to manage their own health and care and to maintain independence as much as possible. They did this by proactively supporting local care homes and arranging appointments at suitable times for patients.
- Patients reported to us that they felt cared for by all staff. People reported they valued their relationships with the staff team and felt they often went 'the extra mile' for them when providing care and support. For example, by providing bespoke vaccination schedules for patients on request.
- All staff were trained in equality and diversity in order to meet the differing needs of the practice population.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice and all of the population groups as outstanding for providing responsive services, except for people with long term conditions and working age people which we rated as good. We rated responsive as outstanding because:

The practice recognised the needs of the population and tailored its services to meet them. For example, there had been the appointment of a primary care matron in order to enhance and drive improvement in the care of complex patients. The practice had implemented 'rescue plans' for vulnerable patients to meet social issues that may have otherwise been undetected. The practice had in line or higher than average patient satisfaction for access to the service and often individualised and changed this to meet patient needs. For example, by offering patients with learning disabilities home visits or the last visit of the day to ensure the environment was calm. The practice responded compassionately to all complaints and used these to drive improvement within the practice.

Responding to and meeting people's needs

People's individual needs and preferences were central to the delivery of tailored services. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice had employed a primary care matron to address the needs of the elderly population and had continued to part fund this when the service could have been removed.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. For example, if the practice referred a patient to another community service, they would try to facilitate the primary care matron attending the assessment visit to ensure appropriate hand over of information.
- The services were flexible, provided informed choice and ensured continuity of care. Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice was very aware that a new housing development was being built and had therefore began looking at workload and capacity within the practice to manage this. The practice had completed an appointments audit to ensure the patients were being seen by the most appropriate clinician and had made changes to staffing as a result of this.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the practice offered home visits or the last appointment of the day to patients with learning disabilities to ensure the environment was maximised to their needs.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines, for example a weekly or monthly blister packs and large print labels.

Older people. This population group was rated as outstanding because:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme. All patients we spoke with on the day of inspection knew who their named GP was. Patients could choose who they wanted their named GP to be and could swap this at any stage of their care. The practice also used a regular locum to aid continuity of care. Patients commented positively that they could get appointments with their named GP. This was also reflected in the national GP patient survey outcomes, where 90% of patients commented that they got to speak to their preferred GP. This was 34% above the local and national averages.
- There was a primary care matron in post, funded jointly by the community provider and the practice. The matron regularly undertook social prescribing in order to signpost patients to the appropriate services. This also included organising regular 'help hubs' in the local community in accessible environments such as local cafes and village halls. These were attended by external speakers to offer advice and support to patients from

Are services responsive to people's needs?

organisations such as Age UK and the dementia association. These were well attended events and were open to all patients in the area, including those not registered with the practice.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and primary care matron also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability. Patients under the care of the primary care matron had direct access to this service, as did local community teams. This aided quick access to care where it was required.

People with long-term conditions:

- 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.
- The practice held regular bi-monthly meetings with the local district nursing team and hospice team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people. This population group was rated as outstanding because:

- 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 proactively followed up patients that did not attend hospital and practice appointments and documented the reasons in the patients notes. If there was any cause for concern, the patients were referred on immediately to the appropriate services.
- There was an information board in reception that gave patients of teenage age sexual health advice and signposting to local services. There was also a section informing patients of when childhood immunisations were due and which ones were due to allow patients to fully understand their care and treatment.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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.
- The practice had implemented an online repeat prescription ordering service for the ease of people that may not be able to attend the service during normal working hours.
- There were dedicated telephone appointment slots built in to the appointments system for working age people that could not attend the practice.

People whose circumstances make them vulnerable. This population group was rated as outstanding because:

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice supported a local home for patients with a learning disability. The practice had a very positive relationship with the home. We spoke with the home who reported that the practice always had the patients best interest at heart and that the practice worked closely with them to ensure this was made possible.
- The practice ensured that home visits were completed regularly for patients with a learning disability. If patients chose to attend the practice, they were always given the option of having the last appointment of the day to ensure a calm and quiet environment was available.
- There was a very small homeless community within the practice population. The practice ensured that access to appointments was always available and personalised care to meet patient need. People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

People experiencing poor mental health (including people with dementia). This population group was rated as outstanding because:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- There was a primary care matron in post who held a list of all patients diagnosed with dementia and a list of all carers. If a carer was admitted to hospital, the matron

Are services responsive to people's needs?

visited the patient being cared for to ensure an appropriate care package was in place if required and that medicines were being managed effectively. Feedback from external stakeholders including the district nurses reported that this service had improved the care for patients in the area. There was a clear audit plan in place to assess whether this had reduced admissions to accident and emergency, though the practice was the second lowest for admissions within the CCG.

- Patients with mental health conditions who failed to attend appointments were proactively followed up by a phone call from a GP.
- The primary care matron had run a dementia information event in the local community to inform patients about the condition and signpost them to local services. This was attended by an external speaker and was open to patients not registered with the practice. These events were well attended.

Timely access to care and treatment

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.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.

Results from the national GP patient survey across all areas measured were higher than the local and national averages and in some cases exceeded them by some margin. Patients reported that the appointments system was easy to use and that the reception staff helped to navigate them through the system where required.

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. Complaints were used as a tool to drive improvement at all levels within the practice.

- Information about how to make a complaint or raise concerns was available both in the practice and on the practice website. Staff treated patients who made complaints compassionately and used all complaints as a learning opportunity. The practice operated a 'no blame' culture and ensured all verbal complaints were recorded as a chance to gain feedback. The practice also collated positive feedback to support good practice.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the practice had reviewed best practice for cancer pathways following a complaint and found that they had followed appropriate guidance. However, they had decided to put an extra safety net in place following a complaint relating to cancer care. This included an extra blood test at the time of any scans.

Please refer to the Evidence Tables for further information.

Outstanding ☆

Are services well-led?

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

There was compassionate, inclusive and effective leadership throughout the practice. The vision and aims for the practice was available for all staff and patients and was reflected in the high morale and performance of all staff. Staff were proud to work for the practice and put the needs of the patients first. The practice was actively involved in the community and offered education events to all patients, regardless of whether they were registered with the practice. Management had full oversight of the performance of the practice and used this to drive positive change, sustainable improvement and a positive culture. Management actively promoted training opportunities and staff development and were innovative in their succession planning to meet patient demand. The practice was keen to upskill staff and promote internally to drive continuous improvement.

Leadership capacity and capability

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

- Leaders were experienced and knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Staff commented that managers were compassionate, inclusive and effective.
- Leaders at all levels were visible and approachable. Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. There was a deep and full understanding of the challenges at local and national levels which the practice took in to account and tackled with a positive approach. The practice ensured they provided the most appropriate skill mix to ensure patients were seen at the right time by the most appropriate person. This included upskilling staff and employing alternative staff, such as a primary care matron.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a stretching, yet realistic strategy and supporting business plans to achieve priorities. 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.
- Ideas generated by all staff were consistently implemented, and had a positive impact on quality and sustainability of services. For example, the appointment of a healthcare assistant had improved the workflow and allowed nurses more structured time to complete long term condition reviews.
- The strategy was in line with health and social priorities across the region and nationally. The practice planned its services to meet the needs of the practice population and had a full understanding of the impact of development plans in the area. The practice had already planned for how it would meet these and was confident in their succession planning.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

Culture

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

- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. Staff had confidence that issues would be addressed in a timely manner.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.
- 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. The practice used all feedback, including complaints, as a positive learning opportunity.
- There were processes for providing all staff with the development they need and development was actively encouraged and celebrated. This included appraisal and

career development conversations. All staff received regular annual appraisals in the last year and reported they were individualised and supported them to achieve their goals. Staff were supported to meet the requirements of professional revalidation where necessary.

- Clinical staff 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. This was reflected in the low turnover of staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally and their differences as individuals were recognised.
- There were positive relationships between staff and teams. This was also reflected in patients' comments.
- A member of staff had received a primary care award and the practice ensured this was celebrated among the team.

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. A systematic approach was taken to working with other organisations to improve care outcomes. This included with the local ambulance service, social services and therapy teams. Feedback from several of these teams was positive about the support structures in place for patients.
- Staff were clear on their roles and accountabilities for all aspects of their job, including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. These were proactively reviewed to reflect best practice.

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. Any identified risks were managed quickly, effectively and communicated to staff.
- The practice had processes to manage current and future performance. There was a strong succession plan in place which reflected the practice, local and national issues and how the practice planned to proactively adapt to them.
- Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints. These were used to drive improvements in care and demonstrate best practice.
- 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.
- 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. For example, the practice had completed sessions with reception staff when the primary care matron was appointed to ensure they fully understood the role and could signpost patients to the appropriate member of staff.

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 which had resulted in positive outcomes from both clinical and non-clinical data. For example, the practice were high achievers for the Quality and Outcomes Framework and were in line or above local and national averages for every indicator for the GP Patient Survey.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Outstanding ☆

Are services well-led?

- 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, such as for atrial fibrillation exception reporting. The practice had identified an issue with the clinical coding of these patients, implemented a change and were actively monitoring this.
- 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 effective 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. Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account. This included information from complaints, significant events and communication from external stakeholders. There was evidence of proactive and positive management of these relationships.
- The practice had attempted to set up a patient participation group and a virtual participation group several times. They actively advertised on their website and as this had not been successful, had formed 'help hubs' in order to liaise with patients. This was ongoing work for the practice and had been identified as a key area for improvement. However, external surveys such as the GP Patient survey, friends and family test and NHS choices showed very positive feedback. For example, 100% of patients were likely or very likely to recommend the practice. The practice used this information to inform their planning and future engagement. The service was transparent, collaborative and open with stakeholders about performance. Stakeholders commented that the practice was open, innovative and engaged with initiatives.

Continuous improvement and innovation

There was clear evidence of systems and processes for learning, continuous improvement and innovation.

- There was a fully embedded and systematic approach to improvement. Improvement was seen as the way to deal with performance and for the organisation to learn.
- Staff knew about improvement methods and had the skills to use them.
- The practice could evidence several innovative and continuous improvement methods, such as the employment of the primary care matron, upskilling staff, succession planning and the workflow audit.
- The practice explained that continuous improvement was embedded within the practice culture and staff felt confident to suggest new ways of working to deliver safer, more effective care for patients.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the Evidence Tables for further information.