

Darlaston Family Practice

Quality Report

Darlaston Health Centre
Pinfold Street
Darlaston
Wednesbury
West Midlands
WS10 8SY

Tel: 0121 568 4300

Website: www.darlastonfamilypractice.nhs.uk

Date of inspection visit: 1 November 2017

Date of publication: 27/11/2017

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Contents

Summary of this inspection

Overall summary

Page

2

Detailed findings from this inspection

Our inspection team

4

Background to Darlaston Family Practice

4

Detailed findings

5

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (The practice was rated good at our previous inspection 10 October 2014)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

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 – Good

People with long-term conditions – Good

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 comprehensive inspection at Darlaston Family Practice on 1 November 2017. We carried out this inspection 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 had reviewed correspondence from NHS England alerting all practices about the death of a child with sickle cell disease who died from sepsis, and identified learning points.
- We found a number of issues relating to monitoring of prescriptions, emergency medicines and oxygen. The practice rectified these issues during the inspection.
- The practice provided a holistic approach to assessing, planning and delivering care and treatment to patients. Patients with multiple long-term conditions were offered one annual review. The practice co-ordinated medicine reviews with the annual review of long term conditions. The practice maintained a register of housebound patients and carried out domiciliary visits for long-term reviews and 'flu vaccinations.
- 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.

Summary of findings

- The practice had introduced additional checks for patients with high blood pressure and carried out electrocardiograms (ECG a test to check the heart's rhythm and electrical activity) every two years to identify potential heart problems.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice had participated in locally commissioned services, for example: bowel screening pilot and diabetes prevention programme. The practice nurse had trained to become a mentor for student nurses and the practice was awaiting accreditation to become a placement for student nurses.
- The practice was part of the Clinical Research Network and had participated in 11 research trials during the past two years.

- The GP partners were actively involved in the education and assessment of medical students and GP registrars. One partner was also involved in appraisals for GPs. One of the partners was the training programme director for the local deanery and lectured at the local university.

The areas where the provider **should** make improvements are:

- Complete a risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury.
- Share and discuss all significant events with the staff team to promote shared learning.
- Take a more proactive approach to identifying carers.
- Include details of how to escalate complaints in the response letter sent to complainants.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Darlaston Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Darlaston Family Practice

Darlaston Family Practice is registered with the Care Quality Commission (CQC) as a partnership provider in Darlaston, West Midlands. The practice is part of the NHS Walsall Clinical Commissioning Group. The practice holds a General Medical Services (GMS) contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice operates from Darlaston Health Centre, Pinfold Street, Darlaston, Wednesbury, West Midlands, WS10 8SY.

The patient list is approximately 3,470 of various ages registered and cared for at the practice. The practice has a younger practice population than the national average. The practice provides GP services in an area considered as one of the more deprived within its locality. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial.

The staffing consists of:

- Two GP partners (both male), and one male sessional GP (four sessions a week).
- A female practice nurse.
- A practice secretary and two reception / administration staff.

The practice is open between 9am and 1pm and 4pm and 6.30pm on Mondays, Tuesdays and Fridays, 9am and 5pm on Wednesdays, and 9am and 1pm on Thursdays. During the in hours periods when staff do not answer the telephones, the calls are answered by WALDOC, who will triage, advise and see patients as required. The practice offers pre-bookable appointments and urgent appointments are available for those that need them. Telephone consultations are also available to suit the needs of the patient. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out of hours service, via the NHS 111 service when the practice is closed.

The practice is a training practice for GP Registrars and medical students to gain experience in general practice and family medicine.

The practice offers a range of services for example: management on long term conditions, child development checks and childhood immunisations, contraceptive and sexual health advice. Further details can be found by accessing the practice's website at www.darlastonfamilypractice.nhs.uk.

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 conducted safety risk assessments. 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).
- 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 (IPC). The local IPC team had carried out an audit in September 2017. An action plan had been developed to address the issues identified. At our previous inspection in October 2014 we advised that the practice should maintain copies of the cleaning schedules carried out by its cleaning provider. We saw that the practice had obtained copies of these and they told us they were satisfied with the standard of cleaning provided.

- 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.
- There was an effective induction system for temporary staff tailored to their role.
- 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.
- 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

We found that the practice did not have reliable systems for appropriate and safe handling of medicines. However, the GP partners and staff took immediate action to address the issues before the end of the inspection.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment required strengthening. We saw that the practice stocked a limited amount of emergency medicines. We discussed this with the GP partners, who explained the rationale behind their decision but acknowledged it had not been formalised into a risk assessment. However, by the end of the inspection they

Are services safe?

told us they had ordered the additional recommended emergency medicines. Following the inspection we received written confirmation that an order had been placed and the expected delivery date.

- We found that the oxygen cylinder available to staff was less than half-full. Although the cylinder was checked on a regular basis, the records did not include the amount of oxygen left in the cylinder. We discussed this with the GPs and the practice nurse. The GPs confirmed in writing the day after the inspection that they an agreement in place with a company to supply and maintain the oxygen cylinder and a new cylinder was due to be delivered the following day. They also advised that when checking the cylinder a record would be made of the quantity to ensure sufficient oxygen was available to staff.
- The practice kept prescription stationery securely and but did not monitor or track their use throughout the practice. A monitoring system was put in place during the inspection.
- 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 was a low prescriber of all types of antibiotic items. The practice was the lowest prescriber of antibiotics within the Clinical Commissioning Group for 2016/17 and had lower prescribing rates than the national average
- 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. The practice had an effective system in place to ensure that repeat prescriptions were not issued when a medicine review was overdue.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. However, we saw that the practice had what appeared to be mercury blood pressure monitoring equipment. A risk assessment to reflect guidance from The Control of Substances Hazardous to

Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury had not been completed. The practice did not have access to a mercury spillage kit for use in the event of a mercury spillage.

- 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. 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. Although the practice recorded low level events and actioned them in the same way as significant events, the information was stored separately to the significant events. We also saw that the GPs completed the incident form, rather than the member of staff who raised the event.
- 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. We saw that the practice had acted on correspondence from NHS England alerting all practices about the death of a child with sickle cell disease who died from sepsis. The practice reviewed this as a significant event and identified learning points from the incident.
- At our previous inspection in October 2014 we asked the practice to introduce a formal system for managing and recording action taken in response to safety alerts. We saw that alerts had been logged, and the action taken recorded.
- The incidents relating to the emergency medicines, oxygen and prescriptions were treated as significant incidents and the practice forwarded a copy of the completed significant incident log. The incident log demonstrated appropriate action taken at the time of event and details of the action taken to prevent these incidents happening again, where appropriate.

Are services effective?

(for example, treatment is effective)

Our findings

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

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. The practice had adapted their care templates to include the need to carry out an electrocardiogram (ECG a test to check the heart's rhyme and electrical activity) every two years for patients with high blood pressure for potential heart problems.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice was making use of technology and had introduced clinical photography. Patients were able to send photographs to the GP via a secure email for discussion during telephone consultations.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice had identified 74 patients who were frail or vulnerable. These patients received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice had previously screened all patients over the aged of 65 years with a long-term condition for memory loss. Opportunistic screening now took place when the GPs or practice nurse saw patients.

People with long-term conditions:

- The practice took a holistic approach when reviewing patients with long-term conditions and reviewed all conditions during the one review. The practice nurse had clinical pathways to follow when reviewing patients.

- 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 co-ordinated medicine reviews with the annual review of long term conditions.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice administrator carried out searches to identify new diagnosed patients with long-term conditions and invited them for a review of their condition with the practice nurse.
- Home visits were carried for house bound patients with long term conditions.
- The practice actively monitored patients with diabetes and / or chronic kidney disease to identify new or worsening cases of kidney function caused by the medical condition.
- The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice.
- The most recent published results for 2016/17 showed that 79% of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of asthma control. This was higher than the Clinical Commissioning Group (CCG) average of 77% and national average of 76%. (Their exception reporting rate of 6% was above the CCG average of 3% and below the national average of 8%.)
- Exception reporting is the removal of patients from QOF calculations where, for example, patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.
- 86% of patients with diabetes had a blood pressure reading (measured in the preceding 12 months) within recognised limits. This was higher than the CCG average of 80% and national average of 78%. (Their exception reporting rate of 11% was higher than the CCG average of 6% and national average of 9%.)

Are services effective?

(for example, treatment is effective)

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 in line with the target percentage of 90% or above.
- The practice offered sexual health services, for example screening for sexually transmitted diseases, a free condom service and contraception.

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

- The practice's uptake for cervical screening was 85%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. The practice promoted immunisation campaigns for students during the holiday periods.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Since February 2014, the practice had identified 888 eligible patients and to date, 543 patients had attended for a health check. 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.
- The practice held a register of patients living in vulnerable circumstances including patients who were frail, those with a learning disability and children in need or with a child protection plan in place.

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

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher than the CCG and national averages of 84%.
- The practice currently had 15 patients identified as living with dementia. All of these patients had attended for a review since April 2017.

- 94% 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 above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 96% compared to the CCG average of 93% and the national average of 91%. The percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation was 93% compared to the national average of 89%.

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.

The practice had undertaken seven medicine related clinical audits linked to National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice also monitored the quality of their antibiotic prescribing. One audit looked at whether patients with a cardiovascular score of 10% or more were prescribed cholesterol lowering medicine. The audit results demonstrated an increase the number of patients prescribed appropriate medicine year on year. In October 2017 97% of patients were prescribed appropriate medicine and offered annual reviews with the practice nurse.

The clinicians took part in local and national improvement initiatives. The practice had been part of the Clinical Research Network (National Institute of Health Research) since 2014 and had participated in 11 research trials during that time. The practice had engaged to local initiatives including the bowel screening and pre-diabetes trials. The Clinical Commissioning Group had introduced these trials to all the practices. The bowel screening trial involved following up patients who failed to respond or responded inappropriately to the screening kit. The practice identified these patients on a monthly basis, contacted them and encouraged participation and ordered a new screening kit if required. The practice had identified and contacted seventeen patients in October 2017 and encouraged them to participate in the screening programme.

Are services effective?

(for example, treatment is effective)

The most recent published Quality Outcome Framework (QOF) results showed that the practice achieved 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall exception reporting rate was 13% compared with a national average of 10%.

We saw that the exception rate for one clinical domain (diabetes) were higher than the CCG and national average. We explored this with the GP partners during the inspection. Only the partners completed the coding for exception reporting on the electronic system. They clearly described the rationale for exception reporting patients. We reviewed the records of a number of patients who had been exception reported during 2016/2017. We saw that the reason for exception reporting had been clearly recorded and in each case the exception reporting was appropriate.

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.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. We saw evidence that the GP trainers monitored the performance of GP registrars and discussed issues as they arose.

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.

- 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 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.
- The clinical staff at the practice met every three months with the community nurses, palliative care team and the community matron to discuss patients identified with palliative care needs and those identified as frail or vulnerable.

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.
- The practice was effective in referring patients with possible cancer. Data from Public Health England showed that 47% of new cancer cases (among patients registered at the practice) were referred using the urgent two week wait referral pathway. This was comparable with the CCG average of 49% and the national average of 50%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- 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. The practice nurse told us about the services in the local community that they signposted patients to.

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.

Are services effective?

(for example, treatment is effective)

- 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.

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.
- All of the 31 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients commented that they received an excellent service, and they felt that all staff listened to what they had to say.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Three hundred and eighty one surveys were sent out and 116 were returned. This represented about 3% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 88% of patients who responded said the GP gave them enough time compared with the CCG average of 83% and the national average of 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 94% and the national average of 95%.
- 91% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 82% and the national average of 86%.
- 100% of patients who responded said the nurse was good at listening to them compared with the CCG and national averages of 91%.

- 99% of patients who responded said the nurse gave them enough time compared with the CCG average of 91% and the national average of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG and national averages of 97%.
- 100% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG and national averages of 91%.
- 90% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 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, although only English, informing patients this service was available. Staff were aware of patients who used British Sign Language and arranged support for appointments as required. We also saw evidence that interpreters were booked for appointments.
- Staff communicated with patients in a way that they could understand, for example, communication aids were available.

The practice identified patients who were carers. The registration form asked patients if they were a carer or had a carer. A carer's pack was available and contained information about services. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 16 patients as carers (less than 0.4% of the practice list).

- Carers were offered an annual health check and flu vaccines. Although the practice did not have a designated member of staff who acted as a carers' champion, the practice nurse was aware of the various services in the local community to support carers and bereaved patients. The practice nurse was mindful about exploring whether patients were also carers during consultations.

Are services caring?

- Staff told us that if families had experienced bereavement, their usual GP sent them a condolence letter. The letter gave advice on how to find a support services, and invitation to contact the practice if they needed further support.

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 above the 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 84% and the national average of 86%.
- 84% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 79% and the national average of 82%.
- 100% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 99% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

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

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.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. 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: appointments until 6.30pm three times a week, on-line services such as repeat prescriptions and a dedicated telephone number for booking long term condition reviews.
- The practice improved services where possible in response to unmet needs. For example, signposting patients to other services within the health centre for advice on finance, housing and employment and sexual health screening and condom service.
- 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, home visits were provided for housebound patients and telephone consultations for patients unable to access the practice within normal opening times.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- 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.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice maintained a register of patients who were housebound and the GPs and practice nurse also accommodated home visits for these patients.

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 meetings with the local district nursing team and community matron to discuss and manage the needs of patients with complex medical issues.
- The practice offered home visits for housebound patients with long-term conditions.

Families, children and young people:

- 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.
- One of the GP partners had additional qualifications in paediatrics and child health; obstetrics and gynaecology and sexual and reproductive health.
- The practice co-hosted weekly antenatal clinics with the community midwives.
- The practice co-ordinated the child health surveillance and childhood immunisation clinics with the health visitor clinics held in the same building.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when available or signposted to appropriate walk in or urgent care centre.

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. Although the practice did not offer extend hours, GP appointments were available until 6.30pm three days a week.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours. Patients could send photographs via a secure email to the practice for discussion during the telephone consultation.

Are services responsive to people's needs?

(for example, to feedback?)

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability or who were identified as frail.
- The practice worked with the palliative care team and community nursing teams to support patients

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

- The practice co-hosted a weekly mental health clinic with the community mental health nurse.
- One of the GPs had undertaken additional training in substance misuse and management of alcohol problems. This GP supported shared care agreements for patients with substance misuse and worked closely with the local substance misuse team.
- Opportunistic screening for dementia took place when the GPs or practice nurse saw patients.
- Patients with a mental health diagnosis were offered an annual review of their physical health needs.

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.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed patients' satisfaction with how they could access care and treatment was comparable to local and national averages. Three hundred and eighty one surveys were sent out and 116 were returned. This represented about 3% of the practice population. This was supported by observations on the day of inspection and completed comment cards.

- 70% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 71% of patients who responded said they could get through easily to the practice by phone compared with the CCG and national averages of 71%.

- 72% 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 compared to the CCG average of 80% and the national average of 84%.
- 72% of patients who responded said their last appointment was convenient compared with the CCG average of 78% and the national average of 81%.
- 71% of patients who responded described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 56% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 57% and the national average of 58%.

The practice had reviewed these results and developed an action plan to address the areas where the results were less than average. Actions taken included:

- Promoting the use of on line service, with 20% of the practice population registered to use them.
- The introduction of a dedicated telephone number to book long-term condition reviews.
- The introduction of a system to enable the cancellation of appointments by text message.
- An increase in sessional GP clinics to four per week, plus increase in appointments per clinic.
- The continual review of the number of appointments offered resulting in an increase of appointments provided during 2016-17.
- An enhanced agreement with a local GP led service to receive calls when reception was closed. The agreement covered triaging patients, providing advice, and seeing patients either in person or at home. The clinicians had access to the electronic patient notes.

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. Seven complaints were received in the last year. We reviewed four complaints and found

Are services responsive to people's needs? (for example, to feedback?)

that they were satisfactorily handled in a timely way. However, we noted that the response letter sent to the complainant did not contain details of how to escalate their complaint if they were not happy with the response from the practice.

- We saw that the practice responded to comments left on the NHS Choices website.

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. As a consequence of a complaint, the practice now offered patients phlebotomy (blood taking) appointments at the local hospital, when the next appointment was not convenient at the practice for the patient.

Are services well-led?

Good 

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

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.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. The practice nurse and administration staff spoke highly of the support provided by the partners.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The GPs proactively supported the practice nurse to complete mentor training, so the practice could apply to become a placement for student nurses from a local university.
- The GP partners were actively involved in the education and assessment of medical students and GP registrars. One partner was also involved in appraisals for GPs. One of the partners was the training programme director for the local deanery and lectured at the local university.

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. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. The practice's vision was to provide excellent holistic healthcare in a non-discriminatory manner to patients irrespective of race, religion, nationality, marital status, age, sexual orientation, disability and colour.
- 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. The practice planned its services to

meet the needs of the practice population. The practice had participated in pilot schemes funded by the Clinical Commissioning Group (CCG) which had since been introduced to all practices.

Culture

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. Staff told us they were supported to develop their skills and expand their roles.
- 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. We saw that patients received apologies where appropriate and a clear explanation about what had occurred. 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.
- 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.
- 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. It was evident when speaking with the GPs and staff that they cared about each other as a team.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

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

Are services well-led?

Good 

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

- 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.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

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 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 Medicines and Healthcare Products Regulatory Agency (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.
- 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. For example, patients submitting photographs for discussion during telephone consultations.
- 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 a patient participation group (PPG). The practice acknowledged the challenges around organising regular meetings and none had been held during 2017. However a member of reception staff had contacted each member of the PPG to ask if they wished to discuss any issues or concerns. The practice planned to organise a meeting for early in 2018.
- The service was transparent, collaborative and open with stakeholders about performance.

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. The practice had introduced a secure email for patients to send photographs for discuss during telephone consultations.
- The practice had participated in locally commissioned services, for example: bowel screening pilot and diabetes prevention programme. The practice was also part of the Clinical Research Network and had participated in 11 research trials during the past two years.
- The practice made use of internal reviews of incidents and complaints. Learning was shared and used to make improvements. For example: the practice had reviewed correspondence from NHS England alerting all practices

Are services well-led?

Good 

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

about the death of a child with sickle cell disease who died from sepsis. The practice had identified learning points from the incident and shared these with the staff team.