

Hollyoaks Medical Centre

Quality 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 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 

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hollyoaks Medical Centre on 9 February 2018 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 by discussing them at their monthly meetings.
- 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.
- The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.
- The practice responded to the needs of its population and offered daily home visit sessions and daily nursing home visits due to the large number of older patients registered at the practice.

- The practice offered the carers at the residential homes looking after their registered patients the chance to register as a temporary patient and have the flu vaccination. In the last year 19 carers from the care homes did so.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Staff were encouraged to develop.
- The practice was very proactive in diagnosing and initiating treatment for atrial fibrillation (AF). Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. The practice had purchased two machines with which AF could be diagnosed and then treatment could be started within hours instead of sending patients to secondary care where it would take longer.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Hollyoaks Medical Centre

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 second CQC inspector and a GP specialist adviser.

Background to Hollyoaks Medical Centre

Hollyoaks Medical Centre in Wythall Birmingham provides general medical services to approximately 4,540 patients and is in Redditch and Bromsgrove Clinical Commissioning Group (CCG).

The practice population is in the least deprived decile in England. The proportion of children registered at the practice who live in income deprived households is 8%, which is lower than the CCG average of 14%, and for older people the practice value is 8%, which is also lower than the CCG average of 14%. The practice has a higher than average number of patients over the age of 65 (30% in total).

The practice operates under a General Medical Services (GMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice is managed by a single-handed GP supported by two salaried GPs, a practice manager, two practice nurses, a nurse practitioner, a healthcare assistant, plus receptionists and other staff who provide administrative support.

The practice reception is open between 8:30am and 6:30pm Monday to Friday and provides extended hours on a Wednesday evening from 6.30pm to 8pm. Appointments were available throughout this time other than 1pm to 2pm on a Tuesday. During this period they had a duty doctor covering.

When the practice is closed patients are directed to contact the local out of hours service (Care UK) via 111.

The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening services; maternity and midwifery services; treatment of disease, disorder or injury; surgical procedures; and family planning.

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. Staff shared examples of this during the inspection. For example, a vulnerable adult who had been living in very difficult circumstances had been appropriately referred by the practice nurse and was now living in safe sheltered accommodation.
- The practice carried out (DBS
- All staff received up-to-date safeguarding and safety training appropriate to their role. All clinical staff were trained to level three in safeguarding. 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. We saw that an infection control audit was carried out on an annual basis. The latest one was carried out in January 2018 and we saw evidence of actions taken following this.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There was a maintenance contract that allowed for yearly servicing of all

equipment. The practice had a record of equipment calibration and portable appliance testing. Both of these had been carried out in July 2017. 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 and rotas were readily available to staff.
- There was an effective induction system for temporary staff tailored to their role. During the inspection we saw that this had been updated in January 2018.
- 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. The clinicians at the practice were using the NICE interactive flowchart for sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. The practice was trying to recruit an extra GP in order to increase available appointments.

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. The practice nurses regularly attended update courses and received monthly journals to keep up to date.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. This was regularly discussed at CCG meetings.
- 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.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues and these were well managed. For example, the fire risk assessment from January 2018 identified actions which had since been taken.
- There was a health and safety risk assessment which had been reviewed in December 2017. All actions identified had been implemented.
- The practice had carried out a legionella risk assessment in March 2017.

- 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. The practice shared an example where a request for a home visit had been incorrectly managed. The practice learned from this and discussed it at the practice meeting to ensure additional checks were made.
- 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. These were distributed to all the relevant clinical staff and we saw evidence that this was discussed at clinical meetings. For example the practice had shared an alert about a medicine used in women of child-bearing age due to the risk of developmental disorders. Women at risk were identified and action was taken as required.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups

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. We saw that the lead GP had links to the British National Formulary (BNF) which had up to date information about medicines and links to National Institute for Health and Care Excellence (NICE) guidelines on their computer and used these regularly. (NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.)

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The average daily quantity of hypnotics prescribed per Specific Therapeutic group was the same as the CCG and national average.
- The number of antibacterial prescription items prescribed per Specific Therapeutic prescribing data was comparable to the CCG and national average.
- The percentage of antibiotic items prescribed that are Cephalosporins or Quinolones was 7% compared to the CCG average of 4% and national average of 5%.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had an established and centralised recall system (tracker system) to ensure safe and effective delivery of service.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of their medicines.

- The practice carried out vaccination programmes for this age group, including the annual flu vaccine, pneumonia vaccine and shingles vaccine as specified in the national programme.
- Some older patients lived in nursing homes and the practice offered a daily session to the nursing homes.
- The practice offered two walk in surgeries per week on a Monday and Friday morning. This service was available to all patients but often older patients used this service.
- The practice offered home visits each morning to elderly housebound patients. The nurse practitioner also offered a regular weekly clinic for older and housebound patients.
- 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. Over the last 3 months the practice had offered 107 patients a health check. 87 of these checks had been carried out.
- 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.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. The clinics included diabetes, rheumatology, asthma, and vascular/ heart disease. A GP was allocated to each clinic and oversees the clinic.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice was very proactive in diagnosing and initiating treatment for atrial fibrillation (AF). Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. The practice had purchased two machines with which AF could be diagnosed and then treatment could be started within hours instead of sending patients to secondary care where it would take longer.

Families, children and young people:

Are services effective?

(for example, treatment is effective)

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given was 100% which was higher than the target percentage of 90%. The practice nurse reviewed the regular audits received from NHS England to ensure that the children who registered at the practice were up to date with their immunisation.
- The practice did six to eight week health checks for babies and this incorporated post-natal checks.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 82%, which was above the 80% coverage target for the national screening programme.
- The practice offered working age patients extended hours appointments after 6.30pm until 8pm once a week.
- The practice offered online access, pre-bookable appointments and phone consultations.
- The practice offered electronic prescribing for routine prescriptions.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. In the last year the practice had offered 69 health checks and 65 of these were complete. 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 actively communicated with social services as and when needed.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Longer appointments were available when needed.

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

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 100% of patients experiencing poor mental health had received discussion and advice about alcohol consumption which was above the CCG average of 92% and the national average of 91%. 99% of patients experiencing poor mental health had received discussion and advice about smoking cessation which was higher than the CCG average of 96% and the national average of 95%.
- Patients over 65 were referred to a consultant geriatrician/memory clinic or early intervention dementia service at Kidderminster which is nearby to the practice. In the previous year, 26 patients had been referred to the memory clinic. The practice pro-actively referred patients to Healthy Minds (a local mental health service) if needed. The practice displayed the telephone numbers of Dementia UK and the National Dementia Helpline in their reception areas.

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. For example, the practice carried out an audit into the long-term use of a group of benzodiazepines (an addictive medicine) which had risks for patients who were prescribed these for a long time; 18 patients were identified and reviewed in August 2017. When this was re-audited in November 2017 only 7 patients were prescribed this medicine long-term.

- The practice used information about care and treatment to make improvements for patients. For example the clinicians regularly attended CCG meetings to share and learn from best practice. The practice had previously been one of the highest in the CCG for prescribing antibacterial items but this had improved in the last year and their prescribing rates had been reduced despite the higher than average elderly population and the nursing homes the practice looks after.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Are services effective?

(for example, treatment is effective)

For example, Redditch and Bromsgrove CCG was working closely with all practices in the area to reduce the number of patients on a specific asthma medicine as it was no longer the recommended first line of treatment; the practice now had the third lowest number of patients (14) on this treatment in the CCG area.

In the most recent published Quality Outcome Framework (QOF) results, the practice achieved 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 95%. The overall exception reporting rate was 7% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- 100% of patients with atrial fibrillation with a record of a CHA2DS2-VASc score (clinical prediction rules for estimating the risk of stroke in patients) of two or more were currently treated with anticoagulation drug therapy which was higher than the CCG average of 92% and the national average of 88%. The practice was very proactive in diagnosing and initiating treatment for atrial fibrillation AF. This was particularly prevalent as the practice has 30% of patients over the age 65. The practice shared an example whereby AF had been diagnosed and treatment started on the same day for the patient.

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. For example, one of the administration staff wanted to develop further and the practice manager had authorised a business

administration course to enable them to develop further. Another member of staff was helping to train newer members of the reception team as they wanted to be more involved with training and development.

- The practice provided staff with
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

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.

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.
- 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.

Are services effective?

(for example, treatment is effective)

- The practice supported national priorities and initiatives to improve the population's health; for example, stop smoking campaigns, tackling obesity. The practice website also contained information about healthy eating.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Consent to care and treatment

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

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 32 patient Care Quality Commission comment cards we received were positive about the service experienced. This was largely in line with the results of the NHS Friends and Family Test and other feedback received by the practice. There were a couple of areas where the practice was scoring below average scores in terms of access to appointments but the practice was working closely with the Patient Participation Group (PPG) to improve this. The PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 229 surveys were sent out and 111 were returned. This represented about 2% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 86% of patients who responded said the GP gave them enough time; CCG - 88%; national average - 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.

- 84% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 87%; national average - 86%.
- 96% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 94% of patients who responded said the nurse gave them enough time; CCG - 95%; national average - 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 99%; national average - 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 79% of patients who responded said they found the receptionists at the practice helpful; CCG - 87%; national average - 87%.

The practice had recruited some new receptionists in the previous six months and the PPG felt this had been helpful. Patients and PPG members we spoke with spoke highly of the reception team.

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):

- Interpreting services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand; for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Are services caring?

The practice proactively identified patients who were carers. The practice had posters in the waiting area explaining that carer packs were available from reception. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 51 patients as carers (approximately 1% of the practice list).

- A member of staff acted as a carers' champion to help ensure the various services supporting carers were coordinated and effective. The carers' pack was comprehensive and contained information about the support available for carers, referral forms for carer support organisations and the practice policy. The practice also offered the flu vaccination to carers.
- As the practice looked after patients at a number of residential homes the practice also offered the carers at the residential homes the chance to register as a temporary patient at the practice and have the flu vaccination. In the previous year 19 carers at the care homes did so.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. The practice also sent out a bereavement pack with the sympathy card. This contained helpful information about when to reach out for help and support organisations that were available to bereaved patients. We saw an example of this on the day of the inspection.
- The practice also shared an example of how they respected patients' cultural needs and completed cremation forms as quickly as possible so that patients who needed to arrange a timely cremation due to religious needs were able to do so.
- The practice looked after eight nursing homes with approximately 250 patients. We spoke with two care

home managers and they both spoke very highly of the GPs at the practice. They particularly commented on how the lead GP was always willing to speak with patients and relatives during end of life care. They felt the GP dealt with end of life care in a sensitive and caring way.

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

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 80% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 82%; national average - 82%.
- 93% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 91% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

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

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. The practice offered extended opening hours on a Wednesday evening from 6.30pm to 8pm, online services such as repeat prescription requests, advanced booking of appointments, walk in surgeries twice a week, daily sessions of home visits and daily visits to the nursing home.
- The practice sent out text messages two days before appointments to remind patients about their appointment.
- The practice improved services where possible in response to unmet needs.
- 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, an alert came on the computer system if a patient had a hearing impairment or visual impairment so receptionists could help the patient to the desk where required.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. The practice met on a monthly basis to discuss palliative care patients.
- The practice proactively shared information with out of hours services. They regularly attended meetings with the CCG and information we received showed that the practice was ranked as second highest in the CCG for the special patient notes (this is information written by the GP with complex health needs) shared with out of hours.

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 nurse did a weekly community clinic in order to reach out to older patients at the practice.
- The practice was responsive to the needs of older patients, and offered home visits on a daily basis and urgent appointments for those with enhanced needs.

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 to discuss and manage the needs of patients with complex medical issues.
- The practice was very proactive in diagnosing and initiating treatment for atrial fibrillation (AF). AF is a heart condition that causes an irregular and often abnormally fast heart rate. This was particularly prevalent as the practice has 30% of patients over the age 65.

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.
- 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 offered extended opening hours on a Wednesday evening from 6.30pm to 8pm.

Are services responsive to people's needs?

(for example, to feedback?)

- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had 26 patients on the learning disability register and 24 patients had their annual review in the last year.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led dementia clinics.
- The practice had information about local dementia cafes at the local farm for patients and families to receive support.

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.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use. The practice had three telephone lines and an additional emergency line which was used by the hospital, paramedics and out of hours service.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. In some areas the practice was scoring lower than average but the practice was working closely with the PPG to improve their scores. This was

supported by observations on the day of inspection and completed comment cards. 229 surveys were sent out and 111 were returned. This represented about 2% of the practice population.

- 69% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 63% of patients who responded said they could get through easily to the practice by phone; CCG - 77%; national average - 71%.
- 89% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 88%; national average - 84%.
- 86% of patients who responded said their last appointment was convenient; CCG - 84%; national average - 81%.
- 66% of patients who responded described their experience of making an appointment as good; CCG - 75%; national average - 73%.
- 55% of patients who responded said they don't normally have to wait too long to be seen; CCG - 55%; national average - 58%.

In order to address some of the lower than average scores the practice had been working with the PPG to encourage patients to use online facilities to book appointments. Also the practice had released more appointments so that it reduces the pressure on the phone in the mornings. Routine appointments can now be booked 8-10 weeks in advance. The practice was also trying to recruit an additional GP to provide more appointments.

The practice routinely opened from 8.30am to 6.30pm with a one hour closure between 1pm and 2pm on a Tuesday. The practice provided extended hours on a Wednesday from 6.30pm to 8pm and was also providing winter pressure appointments after 6.30pm to their patients. The practice worked with the PPG in making the opening hours clear in the reception area and on their website.

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.

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

- 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 a selection of these complaints and found that they were satisfactorily handled in a timely way.
- 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, we reviewed a complaint about the length of time the practice took to make a diagnosis and we found this complaint was handled appropriately.

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 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. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- The practice was looking at the future and as there was one partner and two salaried GPs they are actively trying to add another GP to the partnership.

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. All members of staff were clear on what their roles and responsibilities were.
- 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. For example the practice offered daily home visits each morning and a GP visited the care homes daily.

- The practice monitored progress against delivery of the strategy.

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. All staff we spoke with on the day of the inspection told us they could always discuss anything with the GPs and practice manager.
- 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. For example the practice shared an example where the pharmacist had made an error on a new prescription for a patient. The practice learned from this case and ensured that the GP checked all new prescriptions before being issued. 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. We saw a number of examples of staff given the opportunity to develop in their roles and undertake new courses for example the NVQ in business administration so that one of the administration staff who dealt with scanning documents could progress in their role.
- 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. Clinical staff met on a monthly basis as did non-clinical staff.

Are services well-led?

Good 

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

- There was a strong emphasis on the safety and well-being of all staff. The practice manager had ensured that staff were not lone-working and that late shifts were shared between all members of the team on the rota.
- 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.
- There were positive relationships between staff and teams.

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.
- Staff were clear on their roles and accountabilities 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.

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. The performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.

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

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group. We spoke with three members of the PPG and they felt

Are services well-led?

Good 

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

valued by the practice. The practice had listened to their views and started to improve the notice board in the main reception with their recommendation. They had also started to make improvements to the practice leaflet following their recommendation.

- 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.

- Staff knew about improvement methods and had the skills to use them. For example they worked closely with the CCG and took on board their comments. They improved their antibiotic prescribing following recommendations from the CCG.

- The practice had reviewed respiratory review rates and noted they were lower than the CCG average. By increasing the number of available home visits the practice increased the number of respiratory reviews to be in line with the CCG average.

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.