Park View Surgery

Quality Report

23 Ribbleslade Place
Preston
Lancashire
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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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection 8 April 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

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 Park View Surgery on 5 December 2017 as part of our inspection programme to inspect 10% of practices before April 2018 that were rated Good in our previous inspection programme.

At this inspection we found:

- The practice generally 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. However, actions to manage the low risk of legionella in the practice water system needed to be implemented. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.) Also, risk assessments for staff working conditions and for emergency medicines held by the practice needed completion.
- 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. There was a practice quality lead who managed many aspects of practice quality improvement.
- Staff acted on information in patient safety alerts although these actions were not always clearly documented.
- 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.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw three areas of outstanding practice:

- The practice clinical pharmacist worked with the lead pharmacist for medicines management training at the hospital to improve the way that discharge summaries were written. This work had resulted in further training for both junior and senior pharmacists at the hospital and a revised protocol for producing patient discharge summaries for all patients discharged from the hospital. We saw evidence that the lead hospital pharmacist had affirmed that this work had reduced errors made in patient hospital discharge summaries and the practice confirmed that there were fewer observed inaccuracies since this intervention.
- The practice quality lead took the lead in working with the local safeguarding team and a home for children with complex needs. As a result of this, several changes to procedure were made, the home employed a nurse to act as a focus for the children's health needs and communications with the children's service were improved. The practice clinical pharmacist also visited the home to advise on the storage of medicines. Also, as a result of this work, staff from the local safeguarding team reviewed how all children known to the local child and adolescent mental health team were transferred from other areas and subsequently managed. This improved patient safety for all local practices with regard to the transfer of patients from outside the area.
- Practice staff worked closely with staff from a local women's probation service facility. They arranged for staff from the service to attend a practice meeting in order to set up procedures for prescribing medicines for patients in the service. This improved procedure associated with prescribing for these patients and ensured better patient safety.

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

- Continue to implement the policy to reduce the risk of legionella in the practice water system.
- Consider introducing a confidential health questionnaire to risk assess working conditions for new staff.
- Consider documenting a formal risk assessment for emergency medicines held in the practice.
- Look at improving the documentation of actions taken as a result of patient safety alerts.
- Continue to improve the identification of patients who are also carers.

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

Park View Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Park View Surgery

Park View Surgery is situated at 23 Ribbleslade Place close to the city centre of Preston in a residential area at PR1 3NA and is part of the NHS Greater Preston clinical commissioning group (CCG). Services are provided under a personal medical service (PMS) contract with NHS England. The surgery is housed in converted and extended residential accommodation and offers access and facilities for disabled patients and visitors. There is a stair lift to first floor treatment and consulting rooms. The practice website can be found at: www.parkviewpreston.co.uk

There are approximately 6080 registered patients. The practice population includes a higher number (36.9%) of people aged between 20 and 40 years of age in comparison with the national average of 27.5% and the local average of 28.3%. There are a lower number of people under the age of 20 and over 65 years of age compared to the local and national averages. Public Health England (PHE) indicates that 33.8% of the practice population are of non-white ethnicity.

There are high levels of deprivation in the practice area. Information published by PHE, rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The average life expectancy for both men and women is lower than national averages; 75.5 years of age for men (79.4% nationally) and 80.2 years of age for women (83.1% nationally).

The practice opens from 8am to 6pm Monday to Fridays and extended surgery hours are available on Monday from 6pm to 8pm and 9am to 12 noon on Sunday at a neighbouring practice. When the practice is closed, patients are able to access out of hours services offered locally by the provider GotoDoc by telephoning NHS 111.

The practice has three GP partners (two male and one female) one salaried GP (female), a clinical pharmacist, a locum practice nurse, an assistant practitioner, a phlebotomist, a practice manager and deputy practice manager and seven reception and administration staff.

The practice is a training practice for doctors who wish to gain experience as GPs and also provides teaching for medical students.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. There had been a legionella risk assessment carried out which had indicated that risks of legionella in the water system was low. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.) However, the practice was not taking steps to ensure that risks remained low as indicated by the assessment. We were told that regular monitoring would be commenced and we were sent a policy for this following our inspection. Also, risk assessments for suitable working conditions for new staff in the form of confidential health questionnaires were not carried out and we were told that this would be done in the future including for staff who had been recently employed. There was 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 comprehensive 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 and contact numbers for staff were displayed in administration and treatment rooms. Staff and GPs demonstrated an in-depth knowledge of safeguarding.
- 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. All staff had completed equality and diversity training. The local children's social care service had allocated a named senior manager to the surgery in October 2017 to further improve communication with the practice.
- 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). We saw that IPC audits had been conducted in July and October 2017. The practice nurse was the practice IPC lead. This nurse had recently left the practice direct employ but was working on three days a week as a locum until a replacement could be found. The assistant practitioner was intending to become the new IPC lead and we were told that the practice was planning training for her in this role.
- 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 new and locum 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 and GPs had trained in the management of 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.

Good

Are services safe?

- 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. There was a comprehensive protocol that allowed for incoming communications to be handled by defined staff members and this process was audited monthly by GPs to ensure compliance.
- Referral letters included all of the necessary information and urgent referrals were made in a timely fashion and monitored to ensure that patient appointments were made.
- All staff making patient appointments were trained as "care navigators" to ensure that patient appointments were made appropriately and new staff were given written information on this.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice held emergency medicines safely and we noted that there was no written risk assessment in place to identify those drugs that were not kept in practice. Staff told us that they would discuss this again and record the outcome of that discussion. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. The clinical pharmacist had started in the practice 18 months previously as part of a pilot scheme by NHS England and carried out much of the practice work around medicines.
- 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.
- 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. There were quarterly safety meetings where incidents were discussed and actions taken as a result of incidents were reviewed. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following an emergency situation in the practice, staff were reminded of the emergency call system and the need to review GP appointments to ensure that other patients could be seen in a timely way. The practice quality lead analysed significant events and compared them to previous years to identify trends and promote good practice.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. We saw that actions were taken as a result of safety alerts although these were not always clearly documented.

Good

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. For example, the practice clinical pharmacist had developed a clinical pathway for managing blood results for blood glucose levels for diabetic patients.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Prescribing data for the practice for 01/07/2015 to 30/06/2016 showed that the average daily quantity of hypnotics prescribed per Specific Therapeutic group was comparable to local and national averages; 0.82, compared to 0.74 locally and 0.9 nationally. (This data is used nationally to analyse practice prescribing and hypnotics are drugs primarily used to induce sleep.)
- Similar data for the prescribing of antibacterial prescription items showed that practice prescribing was comparable to local and national levels; 1.15 compared to 1.15 locally and 0.98 nationally.
- Data for the prescribing of antibacterial prescription items that were cephalosporins or quinolones showed that practice prescribing was a little higher than local and national levels; 7.51% compared to 7.17% locally and 4.71% nationally.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had purchased equipment to lend to patients to self-monitor their blood pressure at home and also point-of-care blood testing equipment to give almost instant results for some patient blood testing.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

We reviewed evidence of practice performance against results from the national Quality and Outcomes Framework (QOF) for 2016/17 and looked at how the practice provided care and treatment for patients. (QOF is a system intended to improve the quality of general practice and reward good practice.)

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 medication.
- The practice reviewed patients who had been admitted to hospital unexpectedly and also looked for trends in these admissions. We saw evidence that as a result of care planning for these patients, the total patient unplanned admissions to hospital had decreased from nearly 900 admissions a year in 2015 to around 250 a year in December 2017.
- 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.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. The practice healthcare assistant had trained in the management of patients with long-term conditions and had become an assistant practitioner to assist in the care and treatment for these patients.
- Blood measurements for diabetic patients (IFCC-HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 71% of patients had well controlled blood sugar levels compared with the clinical commissioning group (CCG) and national average of 78%. However, exception reporting for these patients was low at 3% compared to 11% locally and 12% nationally. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.)
- The number of patients with hypertension (high blood pressure) in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 82% compared to the CCG average of

Good

Are services effective?

(for example, treatment is effective)

84% and the national average of 83%. Exception reporting for these patients was lower than local and national averages at 1% compared to 4% both locally and nationally.

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 variable when compared with the target percentage of 90% or above. The practice was above the target for children aged one year old at 92.3%, but below target for those vaccinations given to children aged two years old with an average of 84.9%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. We saw that these arrangements had been audited by the practice quality lead to ensure that best practice had been adhered to.

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

- The practice's uptake for cervical screening was 66%, which was below the 81% coverage target for the national screening programme. The practice had appointed a screening champion to try to improve the uptake of screening and patients who did not attend were contacted.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The practice had addressed the fact that patients had to attend for two appointments for these health assessments. They had purchased equipment to give blood results at the same time as blood samples were taken so that the full assessment could be done in one appointment. We saw that following the increased promotion of these checks to patients, patient attendance had increased from just over 70 in 2015/16 to 180 in 2016/17. 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 homeless people, travellers and those with a learning disability. They also kept a register of patients who lived in the local women's probation service facility.

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

- 78% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the previous 12 months. This was lower than the local average of 85% and the national average of 84% although exception reporting was also lower at 5% compared to 6% locally and 7% nationally.
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher than the CCG and national average of 90%. Exception reporting for these patients was lower at 8% compared to the local average of 11% and national average of 13%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 91% of patients experiencing poor mental health had received discussion and advice about alcohol consumption (CCG and national averages, 91%). Exception reporting for this indicator was lower than local and national rates (practice 7%; CCG 9%; national 10%).

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. A practice quality lead had been appointed to look at all areas of quality improvement in the practice. This staff member carried out searches every month to review practice performance and displayed performance results in the staff rest area so that all staff could see how the practice was performing as well as reporting to staff meetings. Where appropriate, clinicians took part in local and national improvement initiatives. For example, they had participated in a CCG initiative to improve the uptake of patient bowel screening.

Good

Are services effective?

(for example, treatment is effective)

The most recent published QOF results were 93.7% of the total number of points available compared with the CCG average of 94.7% and national average of 96%. The overall exception reporting rate was 8.4% compared with a national average of 10%. We saw evidence that the practice had improved QOF results year on year since 2014/15 when achievement was 90%.

- The practice used information about care and treatment to make improvements. For example, the practice developed a new patient consent form for minor surgery and a leaflet for patients to give them information about the procedures. They were able to show us that there had been no complications as a result of minor surgery at the practice.
- The practice was actively involved in quality improvement activity. The clinical pharmacist carried out medicines audits to check practice prescribing and adherence to best practice guidelines. Where appropriate, clinicians took part in local and national improvement initiatives. We saw that the practice engaged well with the CCG quality contract; a suite of quality improvement plans initiated by the CCG and developed by practices to monitor and improve the quality of clinical care provided to patients, the access to and sustainability of general practice. The practice quality lead carried out weekly and monthly searches related to the improvement plans, the results of which were discussed at practice meetings. She produced a report following discussion which detailed action plans that had been agreed to improve performance. These reports were shared with all staff in the practice.

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. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision-making, including non-medical prescribing.
- 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 and other health and social care agencies to develop personal care plans that were shared with relevant agencies.
- The practice clinical pharmacist had identified that there were sometimes problems associated with patient discharge summaries regarding medicines that had been added or changed for patients discharged from hospital. We saw evidence that she had worked with the lead pharmacist for medicines management training at the hospital to improve the way that these summaries were written. This work had resulted in further training for both junior and senior pharmacists at the hospital and a better protocol for producing patient discharge summaries for all patients discharged from the hospital. We saw evidence that the lead hospital pharmacist had affirmed that this work had reduced errors made in patient hospital discharge summaries and the practice confirmed that there were fewer observed inaccuracies since this intervention. Also, the practice clinical pharmacist was asked to attend a regular interface meeting with hospital staff and to present to the hospital teams regarding common errors associated with discharge summaries.
- Patients who were in need of end of life care, as well as those with complex needs were discussed at formal monthly meetings with staff from other health and social care services. We saw evidence that the minutes

Good

Are services effective?

(for example, treatment is effective)

of these meetings were circulated to relevant staff and any actions taken recorded in the patient records as appropriate. The practice quality lead had worked to increase attendance at these meetings.
- 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. The practice had a patient health monitoring machine in the reception area for patients to take and record their height, weight and blood pressure. This could then be reported to practice staff who also asked for further information such as whether they smoked or not.
- 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 and tackling obesity.
- Patients were encouraged to attend national cancer screening programmes such as breast and bowel screening.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. All practice staff were trained in equality and diversity.
- The practice gave patients timely support and information. The practice made leaflets available during Ramadan to help patients with their health needs at that time.
- 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 23 patient Care Quality Commission comment cards we received were positive about the service experienced. One card mentioned that there could be long waits in the surgery at the time of appointments. This was in line with the results of the NHS Friends and Family Test (FFT) and other feedback received by the practice. We saw that results for the FFT for August, September and October indicated that 100%, 93% and 95% of patients respectively, would recommend the practice to friends and family.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 320 surveys were sent out and 103 (32%) were returned. This represented about 1.7% of the practice population. The practice was in line or higher than local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) and the national average of 89%.
- 87% of patients who responded said the GP gave them enough time; CCG average 87%; national average 86%.
- 94% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and 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; CCG average 85%; national average 86%.
- 93% of patients who responded said the nurse was good at listening to them; CCG average 92%; national average 91%.
- 88% of patients who responded said the nurse gave them enough time compared to the CCG and national average of 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG average 98%; national average 97%.
- 92% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG and national average 91%.
- 88% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 86% and 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 and staff were aware of these services.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. Patients who might have communication difficulties were highlighted on the practice computerised record system.
- 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.

The practice proactively identified patients who were carers. They asked for information at the time of registration and used the practice's computer system to alert GPs if a patient was also a carer. The practice had identified 14 patients as carers (0.2% of the practice list). The practice was aware that this was a low number of

Good

Are services caring?

patients and had appointed a carers champion. This staff member had put together a support pack for carers and was in the process of taking steps to better identify patients who were carers.

Staff told us that if families had experienced bereavement, their usual GP contacted them and sent them a personalised sympathy card. This was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find support services.

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:

- 85% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 85% and the national average of 86%.
- 86% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 91% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG average 91%; national average 90%.
- 89% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and took account of patient preferences. The practice had run a patient survey in 2016 and implemented several actions as a result. For example, they increased GP appointment times from 10 to 15 minutes, increased the number of telephone appointments available and also the number of pre-bookable appointments and online appointments and provided enhanced training to administrative staff in chronic disease awareness and improving customer care. A "You said….We did" report was published for patients. The practice then looked at the national GP patient survey published in July 2017 to assess whether the actions taken had been effective and to identify any further areas for improvement.

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended hours appointments were offered on a Monday evening until 8pm and on Sunday mornings at a neighbouring practice. They also offered online services such as appointment booking and ordering repeat prescriptions.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered. There was a stair lift to assist patients to manage the stairs in the practice.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the practice offered longer appointments to patients with complex needs and used interpretation services for patients for whom English was a second language.
- 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 GP and assistant practitioner accommodated home visits for those who had difficulties getting to the practice.
- Any patients at risk of unplanned hospital admission were given a care plan that was developed with staff from local health and social care services at multidisciplinary meetings. These patients were given a direct telephone contact number for the practice.
- Patients were encouraged to attend the national bowel screening programme. In order to increase patients taking up this service, the practice participated in a clinical commissioning group (CCG) scheme in May 2017. A clinic was held at the practice for patients who had not participated and 28 patients were invited. As a result, 18 screening kits were completed (64%) and two patients were identified as needing further testing. The practice then set up their own protocol whereby any patient who did not participate in the national programme was telephoned by practice staff to encourage them to do so. A screening champion was appointed to take the lead for this work. The practice showed us that they had also asked for training for staff to help them with this, which had been agreed.
- The practice actively encouraged older patients to have the flu vaccination. They contacted those patients who had not attended and we saw evidence that at the time of our inspection, they had increased the uptake of these vaccinations by about 13%.
- All patients at end of life were proactively identified by the practice. GPs in training at the practice had been trained in the recognition of patients at this stage of life. One of the GPs was the lead for end of life care and all these patients had a dedicated GP to ensure continuity of care and to encourage better relationships with the practice.

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. Staff had reviewed the way that patients were recalled for reviews and we saw that as a result they had increased the uptake of these appointments by around 36%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held regular meetings with the local health and social care services to discuss and manage the needs of patients with complex medical issues.
- One of the practice GPs together with the clinical pharmacist ran a service for diabetic patients to initiate insulin. Patients were visited in their own homes if they were unable to access the practice.
- The practice had purchased equipment to allow results of blood tests to measure blood clotting tendencies for patients taking blood-thinning medicines, to be provided at the time of the patient appointment.
- All patients with diabetes or chronic obstructive pulmonary disease (COPD; a lung disease) who had an unplanned admission to hospital associated with their chronic condition were contacted following discharge to ensure that there was an action plan in place to try to prevent further admissions.
- The practice had a number of ambulatory blood pressure monitors which it lent to patients who were experiencing problems with their blood pressure, in order to monitor blood pressure levels.
- The practice gave out leaflets during Ramadan to patients to help them with their health needs at that time. Staff were aware of specific patient medication needs such as the provision of gelatine-free medicines where appropriate.
- Practice staff worked to identify patients at risk of diabetes. They were able to refer patients to a nine-month course as part of a national diabetes prevention programme.

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. The practice also reviewed those children who had not attended booked hospital appointments. They contacted families to discuss non-attendance.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Staff offered baby and child health checks to practice patients and also to two other local practices' patients.
- The practice had a "screening champion" who contacted patients who failed to attend the practice for cervical screening in order to encourage them to attend.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on Mondays and Sunday appointments at another local practice. Appointments could also be booked online and two weeks in advance.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice offered NHS health checks to patients aged between 40 and 74 years of age. Equipment had been purchased to give patient cholesterol blood test results at the time of taking the blood sample, so that blood tests could be done at any time of the day and with only one appointment needed to complete the health check.
- All GP appointments were 15 minutes long allowing for patients to discuss multiple problems and reducing the number of appointments needed.

People whose circumstances make them vulnerable:

- Practice staff worked with the local safeguarding team and a home for children with complex needs. As a result of this, several changes to procedure were made and the home employed a nurse to act as a focus for the children's health needs. Communications with the children's service were improved and the practice ensured that they received reminders of children's booked appointments. Also, as a result, staff from the safeguarding team reviewed how all children known to the CCG child and adolescent mental health team were transferred from other areas and subsequently managed which improved patient safety for this group of patients. The practice quality lead acted as the lead for this work and attended regular meetings with the children's service including meetings when new children joined the service. The practice clinical pharmacist also visited the home to advise on the storage of medicines.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice protocol made it easy for homeless people to register at the practice; all they required as a means of identification was a letter from the local hostel to register a patient with the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- The practice worked with staff from the Salvation Army to encourage vulnerable people to attend the practice for a health check. We were told that plans were in place to survey homeless people to assess their health needs and then hand out leaflets to encourage them to come to the practice. This work was being done with the help of the local health and wellbeing service and was due to start in January 2018.
- Staff worked with community services to provide a drug and alcohol misuse service for practice patients as well as patients from other local practices.
- The practice clinical pharmacist had worked with the hospital lead pharmacist for medicines management training at the hospital to improve the way that patient discharge summaries were written. This had resulted in better quality of discharge summaries for all patients attending the hospital and improved patient safety.
- Practice staff worked closely with staff from a local women's probation service facility. They arranged for staff from the service to attend a practice meeting in order to set up procedures for prescribing medicines for patients in the service. This improved procedure associated with prescribing for these patients and ensured better patient safety. Practice protocols gave easy access to practice services and a simple registration process for these patients.
- The practice actively identified patients who joined the practice who had veteran status.
- Vulnerable patients were discussed at monthly meetings with other health and social care services and we saw that action was taken when needed. For example, we saw evidence that following discussions with other community services, the practice arranged for an elderly patient who was suddenly living alone, to attend a local weekly club that was of particular relevance to the patient's interests.

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 actively followed up any patient who had been admitted to hospital who had been identified as at risk of a memory problem. These patients were asked to book with the practice for a memory assessment with the assistant practitioner.
- The practice quality lead had developed a leaflet giving patients experiencing poor mental health useful contacts and self-referral information. This leaflet had been shared with other practices in the CCG.

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. All GP appointments were 15 minutes long which allowed for issues to be discussed in depth. CQC comment cards that we received commented on the "punctual" service and only one card spoke of waits in the practice.
- Patients with the most urgent needs had their care and treatment prioritised. All children needing a doctor's appointment were seen on the same day.
- The appointment system was easy to use and patients commented on the ease of booking online appointments.

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 or higher than local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 87% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 85% of patients who responded said they could get through easily to the practice by phone; CCG average 72%; national average 71%.
- 85% 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 and national average of 84%.
- 75% of patients who responded said their last appointment was convenient; CCG and national average 81%.
- 78% of patients who responded described their experience of making an appointment as good; CCG average 72%; national average 73%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 59% of patients who responded said they don't normally have to wait too long to be seen compared to the CCG average of 60% and national average of 58%.

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. There were five complaints received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way. Both of these complaints had also been treated as significant incidents.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the booking system for appointments was reviewed following patient difficulties in booking an appropriate appointment with a GP and further training was provided to staff. Also, a new telephone system was installed following a patient complaint.

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.

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. This vision was "to provide a caring, comprehensive and high quality service with a modern approach to traditional general practice. We work hard to ensure that patients receive the care we would wish for ourselves and families". 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 vision was displayed to patients at the reception desk.
- 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 monitored progress against delivery of the strategy. There were weekly business meetings and progress against the annual practice development plan was discussed.

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.
- 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. Patients were offered apologies wherever appropriate and were invited to the practice to discuss any outstanding concerns. 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. Staff training and support were highlighted in the practice business plan.
- 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. Consideration was given to the skill-mix of the practice team to ensure that the best service could be offered to patients.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. All 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. Staff had lead roles in the practice which encouraged ownership and promoted good practice. Time was given to staff to carry out these

Are services well-led?

Good

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

roles. 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 although the process to manage legionella risks needed to be embedded. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.)
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. The appointment of a practice quality lead had had a positive effect on the governance of practice quality improvement.
- 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. At the time of our inspection, the practice was in the process of reviewing the effectiveness of communication methods within the practice and putting together a management process for 2018. This was to incorporate all practice meetings, the purpose and output of those meetings and how actions from meetings were communicated appropriately to staff.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the assistant practitioner met with the quality lead and a GP and, as a result, patient point-of-care blood testing equipment was purchased by the practice to improve services for patients.
- There was an active patient participation group. This group was virtual at the time of our inspection although the practice had plans to start face-to-face meetings in 2018.
- The service was transparent, collaborative and open with stakeholders about performance. The clinical pharmacist had worked with hospital staff to improve the quality of patient discharge summaries.

Continuous improvement and innovation

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

Are services well-led?

Good

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

- There was a focus on continuous learning and improvement at all levels within the practice. The practice healthcare assistant had been supported in completing an assistant practitioner degree with distinction to support the management of patients with long-term conditions. Also, the practice had employed a clinical pharmacist to focus on patient medication reviews and practice prescribing. One of the reception staff had trained to become a phlebotomist (to take patient blood samples). At the time of our inspection, all members of the practice administration team were working towards completing a range of National Vocational Qualifications (NVQs).
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- The practice was a training practice for trainee GPs and also hosted and taught medical students.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. Staff lead roles were given protected time.