Upton Surgery

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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Barrell and Partners on 6 September 2016. Overall the practice is rated as good.

Our key findings across all areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents had been maximised.
- Safe arrangements were in place for staff recruitment that protected patients from risks of harm. Risks to patients had been identified and assessed and well managed to minimise those risks.
- The practice was actively involved with local and national initiatives to enhance the care and treatments offered to patients. Clinical staff were proactive in identifying the current and potential needs of patients with long-term conditions.
- Patients we spoke with said they were treated with respect and they felt involved with decisions about their care and treatment. They commented about how helpful staff were towards them and described their care as good, very good or excellent. Information was available and details of support groups to help them understand about their care needs.
- Practice staff listened and when possible implemented suggestions for improvements and made changes to the way they delivered services. Information about how to make a complaint was available and easy to understand.
- There was a structured programme in place for staff annual appraisals and for planning their training needs. Staff were actively encouraged to enhance their knowledge and skills.
- A clear leadership structure was evident and staff told us they felt supported by senior staff and that there was an open culture throughout. There was a clear vision to promote high standards of care. The governance system monitored the quality of practice wide performance.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system for reporting and recording significant events, and lessons learnt were shared throughout the practice at regular meetings. When there were preventable unintended or unexpected safety incidents patients received an apology and were informed of any actions taken to prevent the same thing from happening.
- Information about safety was recorded, monitored appropriately, reviewed and addressed to minimise identified risks.
- The practice had clearly defined and embedded systems in place to keep patients safe and safeguarded from abuse. Staff had received training that was relevant to their role.
- The practice had a safe system for managing medicines and safe prescribing to ensure that patients only received the medicines they needed.
- We found that senior staff promoted patient safety by adhering to the policy and procedure for recruiting staff. Staffing levels were regularly monitored to ensure there were enough staff to keep people safe.
- The practice employed a pharmacist to manage the dispensary service and ensure that prescribing by GPs was in line with guidance.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Clinical staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and local guidelines were used routinely as part of their work.
- Patients' needs were assessed and care was planned and delivered in line with current guidelines and legislation.
- GPs carried out clinical audits and research projects to ensure that patients received up to date and appropriate care.
- There was a designated lead practice nurse for care of older patients who carried out home visits for those patients who were unable to access the practice. Their project work included checks that reviews were carried when required.

Summary of findings

- The lead nurse for older patients worked closely with a nurse practitioner from the Pro Active Care Team (PACT). PACT staff were responsible for carrying out assessments and developing care plans for 2% of patients considered to be at most risk.
- Patients who were at risk of developing a long-term condition were identified from various sources. As a result of health checks referrals were made and patients were guided to support organisations such as; dementia care and Age UK. Staff had received training appropriate to their role and potential enhanced skills had been recognised and planned for.
- There was evidence of appraisals and personal development plans for all staff for personal progression to enhance delivery of comprehensive patient care.
- Staff worked with multidisciplinary teams to provide up to date, appropriate and seamless care for patients.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data published in July 2016 from the National GP Patient Survey showed that the practice was mostly above local and national averages regarding aspects of care.
- We observed a patient-centred culture and patients we spoke with told us they were satisfied with their care and some said it was excellent.
- Staff ensured that patients' dignity and privacy were protected and patients we spoke with confirmed this.
- Patients had their needs explained to them and they told us they were involved with decisions about their treatment.
- We saw that staff treated patients with kindness and respect and maintained confidentiality.
- Information for patients about the services available to them was easy to understand and accessible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- All patients told us it was easy to make pre-bookable and same day appointments. The practice manager closely monitored the appointments system and took appropriate action when demands were high.
- Patients had the option when ringing for an appointment of speaking with an advanced nurse practitioner at the Clinical Contact Centre who prescribed medicines, provided advice and if necessary booked an appointment for patients to be seen by an advanced nurse practitioner or a GP at the practice.

Summary of findings

- GPs and the lead nurse for older patients provided assessments and treatment for residents of six care homes.
- GPs and the lead nurse for older patients provided assessments and treatment for residents of six care homes.
- The practice leaflet informed patients of which days each GP held sessions to enable them to make pre-bookable appointments with their preferred GP.
- The practice provided enhanced services. For example, avoiding unplanned admissions by carrying out health reviews and the development of individual care plans.
- Information about how to complain was available and easy to understand.
- Evidence showed that senior staff responded quickly and appropriately when issues were raised.
- Learning from complaints was shared with all staff and other stakeholders.
- A practice nurse provided a voluntary service for patients and other people. It comprised of a weekly walk and patients had the choice of a short or long walk. The aim was improved health and was a means of socialising.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for providing well-led services.

- Staff were clear about the vision and their responsibilities in relation to this.
- Practice staff promoted high standards and took pride in delivery of a quality and innovative service to its patients.
- There was a distinct leadership structure and staff were well supported by management.
- Meetings were held and information shared to identify areas where improvements could be made.
- There were policies and procedures to govern activity and these were accessible to all staff.
- There was a strong focus on continuous learning and improvement at all staff levels. GPs carried out research to further enhance the standards of services provided to patients. Senior staff actively sought patient feedback about the services they received and where possible made changes to improve them.
- Senior staff actively sought patient feedback about the services they received and where possible made changes to improve them.

Summary of findings

- The Patient Participation Group (PPG) were active and staff responded positively to them when issues were raised or suggestions put forward. A PPG is a group of patients who represent the views of patients and work with practice staff to improvement services and the quality of care.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Outstanding ☆

The practice is rated good for the care of older people.

- Practice staff offered proactive, personalised care to meet the needs of older patients. The practice had 102 patients aged 90 years or over who lived at home and 148 patients living in six care homes.
- Staff kept up to date registers of patients' health conditions and information was held to alert staff if a patient had complex needs.
- Home visits were offered to those who were unable to access the practice and patients with enhanced needs had prompt access to appointments.
- Extended appointments were available to ensure all aspects of their care needs were assessed.
- A member of the community PACT team worked closely with the practice nurse who was the designated lead for care of older patients. Patients who were at most risk and those who were at risk of unplanned hospital admission were assessed and had care plans developed to support them to remain in their homes.
- Older patients were offered annual health checks and where necessary, care, treatment and support arrangements were implemented.
- Practice staff worked with other agencies and health providers to provide patient support. For example, regular postural stability classes were held at the practice.

People with long term conditions

Good ●

The practice is rated good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. For example, an accredited practice nurse who specialised in diabetes held regular education sessions for these patients.
- Longer appointments and home visits were available when needed.
- Patients with long-term conditions had structured annual reviews to check that their health and medicine needs were being met. Where necessary reviews were carried out more often.

Summary of findings

- Clinical staff worked with health care professionals to deliver a multidisciplinary package of care for patients. Clinical staff had good working relationships with other professionals to promote the delivery of seamless care.
- Where necessary patients in this population group had a personalised care plan in place and they were regularly reviewed.

Families, children and young people

Good

The practice is rated good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- Alerts were put onto the electronic record when safeguarding concerns were raised.
- There was regular liaison and monthly meetings with the health visitor to review those children who were considered to be at risk of harm.
- All children up to the age of 12 years were triaged and if necessary seen the same day.
- Patients and their children told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Childhood vaccinations were in line with the local and national averages.
- Extended hours included early morning appointments from 7.20am two mornings per week and a late evening until 7.30pm. Two Saturdays per month patients can be seen from 8am until 11.30am via a pre-booked appointment. The dates of these sessions vary, reception staff refer to a rota when making these appointments.

Working age people (including those recently retired and students)

Good

The practice is rated good for the care of working-age people (including those recently retired and students).

- The practice had adjusted its services to accommodate the needs of this population group.
- Telephone consultations were provided for those patients who found it difficult to attend the practice or if they were unsure whether they needed a face to face appointment.
- Telephone triaging and extended hours were provided to improve patient access.

Summary of findings

- Online services were available for booking appointments and ordering repeat prescriptions.
- The practice website gave advice to patients about how to treat minor ailments without the need to be seen by a GP.
- Patients we spoke with told us that clinical staff routinely provided healthy living advice to promote their well-being.
- Clinical data told us that breast screening and bowel cancer testing results were in line with local and national averages.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those who had a learning disability.
- Invitation letters for health reviews were sent to patients and once an appointment was made patients received a text reminder.
- One GP was specialised in and was responsible for care of patients who had a learning disability and carried out their annual health reviews with an extended appointment time.
- Practice staff regularly worked with multi-disciplinary teams in the case management of vulnerable patients.
- Staff knew how to recognise signs of abuse, the actions they should take and their responsibilities regarding information sharing.
- There was a clinical lead for managing vulnerable adults and children.
- The practice was pro-active in identifying patients who were carers and had registered 2% of the practice population as carers. There was a dedicated carer's information table in the entrance to the practice that provided information and leaflets about support groups.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated good for the care of people experiencing poor mental health (including people with dementia).

- 92% of patients who experienced poor mental health had received a mental and physical health check during 2014-2015 which was 6% higher than the local and national averages. Patients were involved in developing their care plans.
- Practice staff regularly worked with multi-disciplinary teams in the case management of patients who experienced poor mental health, including those with dementia.

Summary of findings

- GPs carried out assessments of patients who experienced memory loss in order to capture early diagnosis of dementia. This enabled staff to put a care package in place that provided health and social care support systems to promote patients well-being.
- Referrals to other health professionals were made when necessary.
- Staff had a good understanding of how to support patients with mental health needs including those with dementia.

Summary of findings

What people who use the service say

The National GP Patient Survey results published in July 2016 showed the practice was performing in line or above the local and national averages. A total of 220 surveys had been distributed and there had been 132 responses, this equated to a 60% response rate and 1.2% of the practice total population.

- 94% of patients found the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 96% of patients said last time they spoke with a GP they were good at giving them enough time compared with a CCG average of 89% and a national average of 87%.
- 91% of patients found it easy to get through to this surgery by phone compared with a CCG average of 75% and a national average of 73%.
- 92% of patients said the last appointment they got was convenient which was the same as the CCG and national averages.
- 66% of patients felt they did not normally have to wait too long to be seen compared with a CCG average of 60% and a national average of 58%.

Patients we spoke with on the day of our inspection provided feedback that was in line with the national patient survey. Some patients described the service they received as wonderful and extremely high. Patients we spoke with told us that reception staff were courteous and helpful. During our inspection we observed that reception staff conducted themselves in a professional manner.

As part of our inspection we asked for comment cards to be completed by patients. We received 35 cards and they rated the service they received as good, very good, exceptional and one outstanding. Comment cards told us that receptionists were professional and helpful.

Upton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor.

Background to Upton Surgery

Upton Surgery provides care for approximately 10,600 patients. The service covers Upton upon Severn and 15 surrounding rural villages within an area of 70 square miles. The practice holds a General Medical Services contract, a nationally agreed contract. There was a higher than average patient age of 45-85+ years of both sexes registered at the practice. There was lower than average population group of age 0-44 years of both sexes.

The practice provides care for 102 patients who are aged 90 years or over and 148 registered patients who reside in six nursing and care homes. Patients in care homes have a designated GP who visits weekly. The lead nurse for older persons also visits these patients.

The premises were purpose built with all consulting rooms located at ground level for ease of access for patients who have limited mobility. There is a dedicated car park and some spaces allocated for disabled patients.

The practice has six GP partners and one salaried GP. GPs are supported by two advanced nurse practitioners (prescribers) who between them spend 65.5 hours seeing patients with minor ailments. There are also four practice nurses (one was the lead for older patients and a prescriber) and two health care assistants (HCA) who provide cervical screening, vaccinations, reviews of long term conditions and phlebotomy (taking blood samples) services. There is also a full time phlebotomist and a phlebotomist/HCA. A full time pharmacist is employed who provides advice to GPs and advanced nurse practitioners and is responsible for the management of the dispensary. The practice employs a practice director (manager) who has a personal assistant. They are supported by one system and administration support, a senior administrator, an administrator and an administrator/receptionist. There are seven receptionists and two business administrator apprentices.

The practice is a designated training practice for trainee GPs. These are qualified doctors who are learning the role of a GP. Clinical staff also provides training for medical students from Warwick Medical School.

The practice offers a range of clinics for chronic disease management, diabetes, chronic obstructive pulmonary disease (COPD) heart disease, asthma, cervical screening, contraception advice, minor surgery, anticoagulation, injections and vaccinations.

The practice is open from 8am until 6.30pm every weekday.

Appointments times vary between GPs:

- Telephone triaging is from 8am until 9am. Appointments from 8.25am until 11.15am followed by telephone calls to patients.
- Appointments were from 2.30pm or 3.30 until varying times up to 6pm.
- The duty GP and an advanced nurse practitioner will see patients from 8.30am until all patients who have requested same day appointments have been seen.
- Patients can attend the Walk-in minor injury service from 8.30am until 6.30pm. They may be seen by a GP or an advanced nurse practitioner.

Detailed findings

- The practice leaflet includes details of which clinical sessions each GP covers to enable patients to access their preferred GP.

  Extended hours are:

- From 7.20am two days per week.
- 8am until 11.30am two Saturdays each month by pre-booked appointment.

Patients who live in excess of one mile from a pharmacy are eligible to have their prescribed medicines dispensed from the practice. This equates to 70% of registered patients. Medicines can be collected from the practice. Patients who are unable to access the practice have their dispensed medicines delivered to their homes each weekday. The dispensing team are led by a pharmacist who is supported by a team leader, seven dispensers and three dispensing assistants.

The practice has opted out of providing GP services to patients out of hours such as nights and weekends. During these times GP services are provided currently by a service commissioned by NHS Clinical Commissioning Group (CCG). When the practice is closed, there is a recorded message giving out of hours' details. The practice leaflet also includes this information and there are leaflets in the waiting area for patients to take away with them.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before the inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 6 September 2016. During our visit we spoke with a range of staff including six GP partners, an advanced nurse practitioner, the practice nurse who was the lead for older patients, one health care assistant (HCA), the practice manager, two receptionists and one administrator. We spoke with the pharmacist and the dispensing team leader. We liaised with the allocated nurse from the Pro Active Care Team who was present during part of our inspection. We spoke five patients who used the service and three Patient Participation Group (PPG) members who were also registered patients. An Age UK officer was spoken with. We joined the weekly group of walkers when they arrived and saw that they had a good rapport with each other and the practice nurse who led the group. We observed how people were being cared for and

talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 35 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

The practice demonstrated an effective system for reporting and recording significant events and we saw examples which had been reported, recorded and shared with staff.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system for them to record information received.
- The practice carried out a thorough analysis of the significant events. Significant events meetings were held every three months with all clinical staff invited to attend. Lessons learnt were shared with all relevant staff so that improvements could be made.
- When there were unintended or unexpected safety incidents, patients received support, clear information, a verbal and written apology and were told about any actions taken to improve processes to prevent the same thing happening again.
- Safety was monitored using information from a range of sources, including the Medical and Healthcare products Regulatory Agency (MHRA) alerts and the National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave an accurate overview of safety. We were shown records of the appropriate actions that had been taken when the practice received a medical device alert.
- Patient safety alerts were sent to all relevant staff and if necessary actions were taken in accordance with the alerts such as; individual reviews of patients who may have been prescribed a particular medicine. We saw that prescribing changes had been made where necessary to protect patients from inappropriate treatment.
- There had been 57 significant events recorded during 2015 and we saw that they had been dealt with appropriately. We reviewed safety records, incident reports patient safety alerts and minutes of meetings where these were discussed. Lessons learnt were shared to make sure action was taken to improve safety in the practice. For example, a patient had failed to attend for a blood test but did attend after further contact was made. Practice staff developed a register to avoid misses.

Overview of safety systems and processes

We saw that the practice operated a range of risk management systems for safeguarding, health and safety and medicines management. We saw that risks were addressed when identified and actions put in place to minimise them.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The policies were appropriate and accessible to all staff. They included contact details of external professionals who were responsible for investigating allegations. There was a lead member of staff for safeguarding and all GPs had received appropriate (level three) training. All other staff had received training that was appropriate to their role. GPs attended safeguarding meetings when possible and when requested, provided reports for other agencies. Clinical staff kept a register of all patients that they considered to be at risk and regularly reviewed it. Staff demonstrated they understood their responsibilities. We saw documentation which confirmed that appropriate action had been taken when required. Recent action had been taken to protect a patient.
- Patients who were considered to be at risk were discussed during the monthly multidisciplinary meetings when a health visitor was in attendance. Staff monitored children who failed to attend hospital appointments and contacted the parents to discuss this. Quarterly safeguarding meetings were held to review patients and whether any further action was required.
- A notice was displayed in the waiting room and in each consulting room, advising patients of their right to have a chaperone. All staff who acted as chaperones had been trained for the role and had undergone a disclosure and barring check (DBS). 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. Non-clinical staff had received training before they were permitted to act as chaperones. Staff we spoke with demonstrated that they would carry out the role appropriately.

- We observed the premises to be visibly clean and tidy. The lead nurse was the infection control lead and they liaised with the local infection prevention teams to keep up to date with best practice. All staff had received training in infection control and regular refresher training. There was an infection control protocol in place for staff to follow. The practice had not received a report from the recent audit carried out by NHS England but did receive an action plan. The lead nurse described how they had made the necessary improvements. They also provided regular updates to other practice staff. A health care assistant (HCA) carried out annual hand washing checks on all clinical staff. They also did spot checks regarding staff's personal appearance. A weekly checklist was used for all clinical rooms. The lead nurse told us they carried out regular visual checks of the practice and any shortfalls were reported to the cleaning company. There was a cleaning schedule in place and a rota system for deep cleaning such as; chairs.
- We reviewed three personnel files for various staff grades and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks. We saw that appropriate checks were carried out when the practice used locum GP cover and that a role specific induction was provided.
- There were systems in place to ensure test results were received for all samples sent for analysis and the practice followed up patients who were referred as a result of abnormal results. These were checked each day by the duty GP.

Monitoring risks to patients

- A health and safety policy was available to all staff. Environmental risk assessments had been carried out to ensure the premises were safe for patients and staff. We saw recordings where changes had been made to promote safety. A fire safety risk assessment had been carried out and staff carried out regular fire drills and weekly fire alarm testing.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH), clinical waste and legionella. (Legionella is a term used for particular bacteria which can contaminate water systems in buildings).
- Staff told us the practice was well equipped. We saw records that confirmed equipment was tested and regularly maintained. Medical equipment had been calibrated and tested in accordance with the supplier's instructions.
- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. GPs provided cover for each where possible. Other gaps were covered by locum GPs who were known to the practice. There was a role specific induction pack for locum GPs. Nurses worked extra or longer sessions to cover for each other and arranged patient appointments accordingly. Reception staff helped each other during periods of absence.

Medicines management

The practice had an on-site dispensary. Systems were in place to ensure all prescriptions were signed before the medicines were dispensed and handed out to patients, and we saw this working in practice.

- A daily delivery service was available for patients who were unable to access either of the surgeries. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients. We saw evidence that dispensary staff had appropriate qualifications, received annual appraisals and annual competency checks. The pharmacist was responsible for the day to day operations of the dispensary and had developed their own skills. For example, they were a trained prescriber and held regular blood pressure clinics.
- Dispensed medicines were checked by a second trained dispenser or the pharmacist. Staff regularly checked any uncollected medicines and investigated why. The dispensary held stocks of controlled drugs (medicines that require extra checks and special storage

arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff.

- There was a robust process for recording significant events that all dispensary staff we spoke with were aware of. We saw evidence that the practice had reviewed actions from past significant events occurring in the dispensary. Systems were in place to handle high risk medicines, to help make sure that any necessary monitoring and tests had been done and were up to date. Arrangements were made to ensure all prescriptions were signed before the medicines were dispensed to patients.
- Processes were in place to check that medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Records showed fridge temperature checks were carried out daily which ensured medicines, including vaccines, were stored at the appropriate temperature.
- Patients who received high risk medicines such as; methotrexate and warfarin were monitored at recommended intervals by blood test results and health reviews to check that the medicine dosage remained appropriate. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- Blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Practice staff had access to written policies and procedures in respect of safe management of medicines and prescribing practices.

Arrangements to deal with emergencies and major incidents

- All clinical and non-clinical staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks and these were checked regularly.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies of this were held off site to eventualities such as loss of computer and essential utilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Practice staff carried out assessments and treatment in line with the National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing guidelines to ensure that every NHS patient gets fair access to quality treatment.

- Staff had access to up to date NICE and local guidelines and used this information to deliver care and treatment that met patients' needs.
- Clinical staff monitored that these guidelines and were followed through risk assessments, audits and random sample checks of patient records.
- An enhanced service included detailed assessments of patients who presented with memory problems. This ensured timely diagnosis of dementia and appropriate support plans to promote improved life styles.
- Another enhanced service involved all patients of unplanned hospital admissions were reviewed within three days of discharge and where necessary care plans put in place to reduce the risk of re-admission.
- All patients discharged from planned hospital admissions received a phone call and if necessary a visit by a clinician. A GP provided two examples of where more medical care was needed and acted on.
- Monthly multidisciplinary meetings were held with district nurses present. Patients who received palliative (end of life) care were discussed and where necessary changes made to suit their needs and ensure provision of seamless care. Patients who had a range of illnesses were also discussed.
- The allocated Pro-Active Care Team (PACT) nurse team attended meetings. Patients who were most at risk were discussed at these meetings in order to manage their care and to offer additional support to enable them to manage their care needs in their own home. The assessments included patients who were residing in care homes. They also prescribed medicines when required and had access to patient records in the practice. The PACT nurse told us that since November 2015 they had carried out 227 comprehensive assessments for the practice. They also told us that they directed patients to other services such as; dentists, opticians and access to meals and cleaning services.
- The PACT nurse worked closely with the practice nurse who was the lead for older patients. As part of a Fellowship for Older People (specialist training course) the lead nurse was carrying out a project. The purpose of the project was the reduction of unplanned admissions and review of the most vulnerable patients aged 90 years or more. From patient questionnaires received and the practice's frailty index 12 patients had been identified who needed their review brought forward. The nurse told us the next stage of the project was carrying out the reviews. The nurse carried out home visits for patients who were unable to access the surgery. Although there was a higher than average older population the unplanned admission rate for quarter one of 2016 was a value of 18.7 compared with a value of 20.7 nationally.
- The lead nurse for older patients and a named GP carried out regular visits to six care homes where all of the patients were registered with the practice. These complimented the PACT nurse assessments and care plans of some patients and ensured that patients received seamless care.
- A 33 week course for postural stability was originally set up by the practice and the Upton Complex Care team for patients who were at risk of falls. The latest survey results provided were for October 2010 until June 2011. The results were very positive with 100% of patients saying they would recommend the course. This service was still provided at the practice by Sports Partnership to promote patients' health and well-being.
- All clinical staff specialised in health and illnesses such as; sexual health, palliative care and asthma. The team leader practice nurse was also a specialist in diabetes and they held clinics and education programmes for those patients. During 2015 and 2016 80% of patients had attained HbA1c (average blood sugar levels) of less than 59 mmol (amount per litre). The practice will be commencing 'xperts first steps' course in November 2016. Another practice nurse also carried reviews of patients who had diabetes. The team leader held anticoagulant clinics for patients who were prescribed warfarin.

Good

Are services effective?

(for example, treatment is effective)

- A hospital consultant (specialist) held dermatology clinics twice a month at the practice. A practice GP attended these clinics in the role of clinical assistant.
- There was a large display in the waiting area advising patients of the Upton Complex Care Team who provided assessments and practical support. They worked with practice staff in achieving optimal patient care.
- Patients who were at risk of developing a long-term condition were identified from various sources. Computer searches were carried out; alerts form individuals, letters from secondary care, test results, during consultations and information received from carers. Appropriate tests and health checks were carried out. As a result referrals were made and patients were guided to support organisations such as; dementia care and Age UK.
- Trainee GPs provided regular education sessions for parents and grandparents. These involved information about how to understand common children's illnesses to enable them to have confidence in this area. A patient review carried out in 2014 informed that all relatives found it was beneficial in improving their knowledge and management of common childhood illnesses.
- The practice had blood pressure monitoring machines for patients to take away with them for 24 hour monitoring for clinicians to assess their health needs. A patient review carried out in 2014 informed that all relatives found it was beneficial in improving their knowledge and management of common childhood illnesses.
- Clinical staff were working with two other practices, Healthwatch (organisation who provide patient feedback to health providers), the Worcestershire Carers Association, Age UK and the CCG in compiling a presentation to patients. The first event of 'understanding self-care for life' was planned for November 2016.
- Clinical staff were working with other local practices to identify ways of improving patient care. Clinical staff shared information with a view to improving their clinical skills.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Comparisons were also made with the local Clinical Commissioning Group (CCG). QOF data published in July 2016 showed the practice was performing above CCG and national averages;

- The review rate for dementia was 87% which was 3% above the CCG average and 3% above the national average. The practice exception reporting rate was 5% compared with 8% for the CCG and 8% nationally.
- The review rate for patients who had atrial fibrillation (irregular heart beat) was 100% which was 1% above the CCG average and 2% above the national average. The practice exception rating was 6% compared with the CCG average of 7% and the national average of 6%.
- Performance for asthma related indicators was 81% which was 5% above both the CCG average and 6% above the national average. The practice exception reporting rate was 2% compared with 9% for the CCG and 10% nationally.
- Performance for patients with a learning disability was 100% which was the same as the CCG and national averages. There was no practice exception reporting rate.
- Performance for chronic obstructive pulmonary disease (COPD) was 96% which was 5% above both the CCG average and 6% above the national average. The practice exception rating was 12% compared with both the CCG and national averages of 12%.
- The percentage of patients with hypertension whom the last blood pressure reading in the preceding 12 months was 150/90mmHg was 90% which was 4% above the CCG average and 6% above the national average. The practice exception reporting rate was 3%; this was the same as the CCG average 1% below the national average.

The practice overall QOF achievement for 2014-2015 was 100% compared with 97% CCG average and 95% national average.

Clinical audits had been carried out that demonstrated relevant changes had been made that led to improved

patient care. We saw that audits had been repeated (some more than once) to evidence that improvements made had been sustained and where necessary further changes made. For example:

- An audit concerning chronic kidney disease was prompted by a patient who failed to turn up for their review. All patients with this disorder were identified and a system put in place where patients were called every six months and regular annual re-auditing was planned.
- An audit concerning anticoagulant therapy for patients who had atrial fibrillation was triggered due to a change in guidelines. This led to changes in patient care and there were plans in place to re-audit it.
- The practice pharmacist ensured that prescribing was in line with national and local formulary and carried out searches for patients with long-term conditions and those requiring antibiotics to ensure that GP prescribing was appropriate. The pharmacist also carried out patient searches when a patient alert was received regarding medicines.

We saw evidence of other clinical audits that had been carried out and would be repeated. A total of 16 clinical audits had been carried out during the last 12 months.

Effective staffing

Staff had the skills, knowledge and experience to deliver appropriate care and treatment.

- The practice had an induction programme for newly appointed staff that was role specific. This included a dedicated induction for locum GPs. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety, policies and procedures and confidentiality.
- The practice had a training programme in place and extra courses were provided that were relevant to specific roles. Staff told us they were encouraged and supported in enhancing their skills. For example, a practice nurse was undertaking a training course in Fundamentals of Practice Nursing. Staff who administered vaccines could demonstrate how they stayed up to date with changes of the immunisation programmes.
- The learning needs of staff were identified through a system of meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. They told us they could ask for additional support at any time. All staff had received an appraisal within the last 12 months.
- The practice held weekly protected learning time when all staff discussed clinical issues, safeguarding, patient care and operational matters. They invited speaker to these events to talk about specific health conditions and other aspects of care and treatments related to primary care. These contributed to staff knowledge and skills. For example, child sexual exploitation, diabetes podiatry and a pharmacy topic.
- Staff received training that included: infection control, fire procedures, dementia awareness, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient leaflets were available.
- The practice shared relevant information with other services in a timely way. For example, when referring patients to other services and the out of hours care team. Two week referrals were monitored by staff to ensure that patients received a timely response. A monthly report was sent to GPs so that actions could be taken if delays were evidenced.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs in an appropriate and timely way. Care plans were in place for patients who had complex needs and these were regularly updated. The assessments and care planning included when

patients moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- All staff had received training in the Mental Capacity Act (MCA) 2005. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. GPs we spoke with understood the Gillick competency test. It was used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through records and audits to ensure the practice met its responsibilities with legislation and national guidelines. Signed consent was obtained from patients prior to minor surgery and the possible complications had been explained to patients before they signed.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients who received palliative (end of life) care, carers of patients, those at risk of developing a long-term condition and those requiring advice on smoking and alcohol cessation. All eligible patients who attended the practice had received advice on obesity and there was a dedicated session for this service. Patients were signposted to relevant services.
- Patients who had long-term conditions were contacted to remind them when their health checks were due.
- Patients who had complex needs or had been identified as requiring extra time were given longer appointments to ensure they were fully assessed and received appropriate treatment.
- The practice's uptake for the cervical screening programme was 82%; the CCG average was 75% and the national average was 74% for 2014-2015. The practice exception rating was 10% compared with 7% for the CCG average and 6% for the national average.
- The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data published July 2016 told us that;
- 76% of female patients had attended for breast screening during a 36 month period, which was 2% above the CCG average and 4% above the national average.
- 62% of patients had undergone bowel screening in the last 30 month period, compared with 62% CCG average and 58% national average.
- Newly registered patients received health checks and their social and work backgrounds were explored to ensure holistic care could be provided. If they were receiving prescribed medicines from elsewhere these were also reviewed to check they were still needed.
- Childhood immunisation rates for the vaccinations given were comparable to CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 98%, the CCG average was from 80% to 98%. Practice immunisations for five year olds were from 87% to 97%, the CCG average was from 90% to 95%.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and the NHS health checks for patients aged 40–74 years. From 1 April 2015 to 31 March 2016, 329 health checks were carried out and since 1 April 2016 to the present 150 had been completed. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- The practice had a machine that measured patient's weight and compared it with the body mass index (BMI) for determining an acceptable weight. It also measured blood pressure. The written results issued from the

Good

Are services effective?

(for example, treatment is effective)

machine could be given to a receptionist who entered them in the patient's records. There was an adjacent table that provided details of activities available and how to access them. For example; pilates (muscle) exercises, strength and balance classes, other exercise groups, walking, badminton and archery.

- The practice held regular patient education events with speakers invited to attend for topics such as; orthopaedics, urology, eye care and breast care. In conjunction with the patient Participation Group (PPG) practice staff held a 'Your Health in Partnership' event in 2012 involving 24 tables and displays from voluntary and professional organisations. For example, dental and local pharmacies, Alzheimer's Society and Age UK. Approximately 250 patients attended the event. This led onto four more education sessions during 2013 for example, essential health awareness for women.
- In July 2016 four members of staff and two PPG members attended the Upton Primary School fete to promote health awareness. These included knowledge and management of common childhood illnesses, healthy heart promotion, 'a guide to understanding your symptoms' and repeat prescriptions and wastage of them.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that the doors of clinical rooms were kept closed during consultations.
- Reception staff told us they responded when patients wanted to discuss sensitive issues or appeared distressed by offering them a private room to discuss their needs.
- The five patients we spoke with and the three PPG members were complimentary about the way in which all staff communicated with them.
- All of the 35 patient comment cards we received were positive about the service they received and about how staff liaised and kept patients informed.
- Throughout our inspection we observed how staff responded to patients and saw they were treated with respect at all times. We saw that staff were friendly and helpful. Patients told us that staff provided either a good, very good or an excellent service.

Results from the National GP Patient Survey published in July 2016 showed how patients felt about how were treated regarding compassion, dignity and respect. The practice results were above the CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 97% of patients said the last GP they saw or spoke with was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 94% of patients said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 96% of patients said they had confidence and trust in the last nurse they saw or spoke with compared to the CCG average of 97% and national average of 97%.
- 95% of patients said the last nurse they spoke with or saw was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.

Care planning and involvement in decisions about care and treatment

Results from the National GP Patient Survey published July in 2016 showed how patients felt about their involvement in planning and making decisions about their care and treatment. All results were above local and national averages. For example:

- 95% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 82%.
- 93% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- 91% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

We spoke with five patients, three Patient Participation Group (PPG) members and reviewed 35 comment cards on the day of our inspection. All confirmed that patients felt involved with decisions about their healthcare and treatment. Patients spoke positively about the way that GPs and nurses explained their condition and the options available to them about their care needs.

We saw a range of health promotion advice and leaflets about long term conditions were in the waiting area that provided patients with information and support services they could contact.

Good

Are services caring?

The practice leaflet provided information about the operations of the practice and the practice website provided information on how to treat minor ailments.

Staff told us that translation services were available for patients whose first language was not have English.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations including a bereavement service. GPs offered relatives/ carers support and if necessary an appointment was offered or a home visit and referral to a counselling service.

The practice's computer system alerted GPs if a patient was also a carer. The practice had 256 registered carers which equated to 2% of the practice population. Carers were identified from the registration questionnaire, by looking at patient's records and from the dedicated notice board that gave advice about what constituted a carer. The practice had good links with the Worcestershire Carers Association. There was a dedicated table in the entrance to the practice that provided information and details of various support groups including younger carers. Clinical staff told us that they offered guidance and flu vaccinations for carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that practice staff were responsive to patients' needs and had systems in place to maintain the level of service provided. The demands of the practice population were understood and arrangements were in place to address the identified needs of patients. Many services were provided from the practice such as; diabetic clinics, long-term conditions, and weight control advice. Services were planned and delivered that took into account the differing needs of patient groups. For example:

- All requests for same day appointments were triaged and those who needed to be seen were given a same day appointment with a GP or an advanced nurse practitioner even if the sessions were fully booked.
- There were longer appointments available for people with a learning disability and patients with other long-term conditions.
- Urgent access appointments were available for children and those with serious or complex medical conditions. These patients were seen on the day even if the clinical sessions were fully booked.
- Patients with a long-term condition were sent reminders when their health check was due. Patients received text messages to remind them of their pending appointment.
- Home visits were available for elderly patients and those who were unable to access the practice. The practice had 102 patients over the age of 90 years who lived at home.
- There were nurse run anticoagulation clinics at the practice.
- Regular meetings took place to discuss and plan care for vulnerable patients and those with complex needs.
- Patients who were at risk of unplanned admission to hospital were closely monitored.
- There were facilities for patients with a disability, a hearing loop and translation and sign language services were available.
- The practice leaflet informed patients of which sessions GPs covered to assist them in seeing a GP of their choice.
- The lead nurse for the older patients and a named GP made weekly visits to six assigned care homes to assess their health needs. This provided continuity of care for the 148 registered patients living in care homes and cemented relationships with care homes staff.
- The 'Silver Clinic' had been developed for patients aged 90 years or more and their carer's. It provided a direct link to the practice nurse who was the lead for older patients. Patients were assessed for their health conditions, basic activities and daily living skills, psychological assessment, social and environmental assessments. From this a 'problem list' was developed and an action plan put in place. This may involve the assistance of other health and social care professionals.
- A practice nurse organised weekly walks in her own time for patients and others who wished to join the group. The aim of the walks was to improve health and it also served as a means of socialising. Patients were given a choice of a short walk or a longer walk. All those who wished to participate were asked to complete a medical questionnaire for the practice nurse to check that there were no health risks. All routes taken had been risk assessed. The names of each patient who participated were recorded.
- We spoke with an officer from Age UK who told us they maintained close and positive links with the practice and provided non-clinical support services for older patients. Clinical staff made regular referrals to Age UK to promote patients' health and well-being.

Access to the service

The practice was open from 8am until 6.30pm every weekday.

Appointments times varied between GPs to give a variety of access time to clinicians:

- Telephone triaging was carried out from 8am until 9am. Appointments were from 8.25am until 11.15am followed by telephone calls to patients.
- Appointments were from 2.30pm or 3.30 until varying times up to 6pm.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The duty GP and an advanced nurse practitioner would see patients from 8.30am until all patients who had requested same day appointments had been seen.
- Patients could attend the walk-in minor injury service from 8.30am until 6.30pm. They would be seen by a GP or an advanced nurse practitioner.

Extended hours were:

- From 7.20am two days per week.
- 8am until 11.30am two Saturdays each month by pre-booked appointment.
- Appointments could be made by telephone, in person or on line. There were 4,000 patients registered with the on-line service.
- Patients had the option when ringing for an appointment of speaking with an advanced nurse practitioner at the Clinical Contact Centre who prescribed medicines, provided advice and if necessary booked an appointment for patients to be seen by a advanced nurse practitioner or a GP at the practice.

The dispensary was open from 8.30am until 6.30pm each weekday and provided a delivery service for patients who were unable to access the practice.

Results from the National GP Patient Survey published July 2016 showed that patients' were satisfied with how they could access care and treatment compared with local and national averages. For example:

- 91% of patients said they could get through easily to the surgery by phone compared to the CCG average of 75% and national average of 73%.
- 94% of patients said they were able to get an appointment to see or speak with someone last time they tried compared to the CCG average of 89% and the national average of 85%.
- 87% of patients described their experience of making an appointment as good compared to the CCG average of 78% and national average of 73%.
- 85% reported they were satisfied with the opening hours compared to the CCG average of 76% and national average of 76%.

All five of the patients we spoke with and the three members of the Patient Participation Group (PPG) told us they were satisfied with the access to the practice and that they could always get an appointment when they felt they needed one. We received no negative comments from the 35 comment cards about patient's ability to make appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. Information about how to make a complaint was available on the practice's website and at the reception desk.

- The complaints policy clearly outlined a time framework for when the complaint would be acknowledged and responded to and was available in five languages. In addition, the complaints policy outlined who the patient should contact if they were unhappy with the outcome of their complaint. There was a named lead for dealing with complaints. The practice kept a complaints log and there had been 10 (seven verbal and three written) formal complaints received since the 1 April 2016.
- We saw that complaints had been dealt with in an effective and timely way. Explanations were given to patients. For example, a patient complained that they had an incorrect diagnosis. An appointment was made with a GP who explained how the diagnosis had been reached. The patient was happy with this and did not wish to take the complaint further.
- Complaints were discussed with staff during meetings to enable them to reflect upon them and any actions taken to reduce the likelihood of future incidents. Complaints were reviewed regularly during staff meetings to ensure that appropriate actions had been taken.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

Senior staff had a vision to deliver quality care and promote positive outcomes for patients. There was a statement of purpose with clear aims and objectives which staff understood.

- Senior staff had considered the needs of the future. Senior staff had commenced negotiations with local practices to consider future methods of care delivery. The main purpose of this was to achieve improved patients care and outcomes and to comply with Government initiatives.
- The practice had a written three year strategy dated 2016-2019 and held strategy meetings every six months. The purpose of the meetings was to improve patient access, further develop care for frail patients and to peer review referrals to reduce the number of them. GPs, nurses and the practice director (manager) attended these meetings.

Governance arrangements

There was a clear leadership structure in place and staff felt supported by management.

- There was a staffing structure in place and staff were aware of their own roles and responsibilities. Clinical staff had allocated lead roles and had received relevant training for them.
- Staff worked as a team and supported each other in achieving good patient care.
- Clear methods of communication that involved the whole staff team and other healthcare professionals disseminated best practice guidelines and other information.
- A range of meetings were held throughout the practice including weekly clinical governance meetings with a wide range of health topics. Minutes of these shared with other staff to ensure that a streamlined service was provided to patients.
- Practice specific policies were implemented and were available to all staff.
- Clinical staff had an understanding of the performance of the practice and an action plan had been implemented to improve performance.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Clinical audits were undertaken to improve and monitor quality of patient care. These were complimented by the research projects that clinical staff undertook.
- All staff spoken with had a comprehensive understanding of the governance arrangements and performance of the practice. Staff told us there was an open and relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues. Staff said they felt respected, valued and supported, particularly by the partners and practice manager.

Leadership and culture

On the day of the inspection the GP partners demonstrated they had the experience, capacity and capability to run the practice to promote high quality care.

- They prioritised safe, high quality care. All staff we spoke with during the inspection demonstrated that they made positive contributions towards a well- run practice. On-going service improvements and compassionate care was provided. The partners were visible in the practice and staff told us they were approachable at all times and encouraged honesty.
- Staff were aware of the requirements within the duty of candour and clinical staff encouraged openness and honesty. We saw an example where this had been complied with when communicating with a patient.
- The practice had systems in place for knowing about notifiable safety incidents. When there were unexpected or unintended safety incidents practice staff gave affected people reasonable support, information and if necessary, written apology.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff.

Are services well-led?

Outstanding ☆

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

- Staff proactively sought patients' feedback and engaged patients in the delivery of the service. It had gathered feedback from patients through the Patient Participation Group (PPG) and through surveys and complaints received. A PPG are a group of patients registered with a practice who work with the practice to improve services and the quality of care.
- The practice had developed links with a local high school and supported the pupils with an art project. Staff had also attended the 2015 school fete. The Patient Participation Group (PPG) became involved with the school and as a result two pupils had joined the PPG. The chair of the PPG told us that the new members participated well during meetings. The PPG also had three mothers in the group.
- The PPG met regularly and liaised with senior staff between these times. PPG members said they felt the staff listened to them and that changes would be facilitated whenever practicable. For example, they were working with practice staff in developing ways of decreasing the number of patients who did not attend (DNA) for their appointments. Some GPs had made appointments in advance and this practice was stopped. Staff and the PPG were also educating patients about the impact that DNAs had. This had resulted in a 10% reduction in DNAs but 48 hours per week of clinicians time was still lost and work on this was continuing. The PPG had produced its own annual action plan and progress against it was monitored.
- Information was gathered from patients and staff through meetings and appraisals about issues, concerns or where improvements could be made. The PPG members were kept informed about the practice and they channelled the view of patients back to practice staff.

Continuous improvement

There was focus on continuous learning and improvement at all levels within the practice.

- Discussions were in progress through meetings about how they would implement the proposed Clinical Commissioning Group (CCG) model of caring strategy. A GP and sometimes the practice director attended the monthly CCG locality meetings and cascaded information to other staff.
- The practice held quarterly Quality meetings where significant events, complaints, compliments and suggestions were discussed and where necessary action taken. The practice had a written delivery plan with work to be carried out by whom and by when. For example, development of a pre-diabetic register, provision of targeted opportunistic blood tests and monitoring of achievements.
- Practice staff held a range of weekly educational meetings to ensure that patients received appropriate and up to date care. External speakers provided talks on topics such as; stay well health care, diabetic podiatry and pharmacy topics.
- Clinicians carried out regional research programmes that were endorsed by NHS England. Clinical staff had carried out a wide range of research projects. One concerned self- management interventions for 10 patients who report only mild symptoms of their chronic obstructive pulmonary disease (COPD). These patients were given advice about changing and improving their lifestyles to limit the need for extra intervention. As a result of the research clinical staff had adopted this philosophy for its patients.
- The results of a previous research project were published in the British Medical Journal in February 2016. It concerned the management of the optimal blood pressure of patients after they had a stroke or transient ischaemic attack (TIA) (lack of sufficient oxygen to the brain) to reduce the risk of further strokes and TIAs. The result was that active management of the blood pressure was more important than setting a target blood pressure. The article advised that more research was needed.
- Regular health education sessions were held at the practice that provided advice to patients about maintaining their health and well-being. Other health education sessions were provided concerning childhood illnesses.
- In 2014 the practice achieved the General Practice runner up award for training methodologies of clinical and non-clinical staff. In 2016 a GP partner was awarded the Fellowship of the Royal College of General Practice for their significant contribution to the health and welfare of the community.