# Tudor Practice

## 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? | Outstanding |
| Are services well-led? | Good |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at the Tudor Practice on 17 June 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. The practice used learning from incidents to improve services.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example redesigning services to better support patients in primary care and reduce hospital admissions.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, changes to the appointment system to improve access.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders to meet changing needs in primary care and secure future services for patients.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw areas of outstanding practice including:

- The practice had been a key player in developing a successful scheme to reduce unplanned admissions in collaboration with two other practices. The scheme extended beyond the local enhanced scheme by including all patients over 70 years. The senior partner formed a steering group with the

# Summary of findings

other practices involved and employed a service redesign expert to support the project. During the initial stages they visited and listened to a wide range of stakeholders and patients to identify and address challenges faced by organisational boundaries. The organisations were brought together through organised networking events to improve working relationships and understanding of roles. As part of service redesign software was developed to enable the practices to view their patients in the system and intervene as appropriate. The practice initially employed two but now has three community matrons to facilitate hospital discharges and put in place appropriate packages of care to minimise the risk of readmission to hospital. The practices involved maintain a blog to support communication across the partnership. Through this programme of service redesign the practice has made demonstrable improvements to patient outcomes and experiences as well as benefiting the local health economy in facilitating early safe discharge from hospital. To date the practice has reduced the average number of hospital deaths by 90, saved 5800 hospital bed days and reduced admission spend by £1.2 million. As a result of this success three further practices have joined the scheme which covers a population of 64,000. The scheme has led to a fall in hospital readmissions by more than 6 admissions on average each week and the facilitation of early safe discharge for over 200 patients among the participating practices.

The areas where the provider should make improvement are:

- Review and implement ways in which the identification of carers might be improved so that they may receive support.

**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 in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

**Are services effective?**

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were in most areas above CCG and national averages.
- Through innovative work to address unplanned admissions the practice had actively sought to establish strong working relationships with secondary care clinicians, health and social care professionals and third sector organisations in order to better meet patient need and patient outcomes. These had been established through networking and other events.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement, significant improvements had been achieved in relation to antibiotic prescribing.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans in place for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

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- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. For example, initiatives to reduce unplanned admissions and attendances to accident and emergency.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rating of the practice was similar to others for several aspects of care.
- Feedback obtained from patients during our inspection was very positive about the standard of care received.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Patients were signposted to support available to them in a way that was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

**Outstanding**

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. There were positive examples of collaborative and innovative working across multiple health, social care and third sector organisations to the benefit of patients.
- Innovative approaches to providing integrated patient-centred care were seen. Various complementary schemes were in place to ensure patient experiences and outcomes were improved.
- The practice implemented suggestions for improvements from patients and the patient participation group and made changes to the way it delivered services as a consequence. For example, the practice had actively sought feedback from patients and their experiences in the development of innovative services.
- Patient feedback was positive as to how they could access appointments and services in a way and at a time that suited them. Changes to the appointment system had been made based on patient feedback.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

# Summary of findings

- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and stakeholders.

**Are services well-led?**

Good

The practice is rated as good for being well-led.

- The practice had a clear vision with quality and safety as its top priority. They worked in partnership with key stakeholders to deliver their vision which was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles. The views of staff and patients were valued to support service redevelopment.
- Governance and performance management arrangements, focussed on best practice and were patient focused.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients using new technology, and it had a very engaged patient participation group which influenced practice development. Patient feedback was very positive.

# 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

Good

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population. Patients over the 75 years were allocated a named GP to support their needs and care plans were in place for those with complex care needs.
- The practice had been a key player in developing a successful scheme to reduce unplanned admissions in all patients over 75 years in collaboration with two other practices. Through service redesign, the practice had taken an active role in both prevention of admission and facilitating early safe discharge. To date the scheme had achieved significant benefits with 90 less hospital deaths, 5800 hospital bed days saved and reduced admission spend by £1.2 million by the practice. It had also resulted in improved working relationships across organisational boundaries. As a result of the success three further practices had joined the scheme now covering a population of 64,000.
- The practice had also been proactive in participating in other successful pilot schemes within the CCG which benefited elderly patients and complemented the unplanned admissions scheme. This included the elderly care support nurse project in which a nurse was specifically employed (and shared between six local practices) to review all patients over 75 years to identify and help address any unmet care and support needs. The practice has also participated in the ambulance triage scheme in which the GPs provide advice to paramedics and support patients in primary care as an alternative to accident and emergency.
- The practice was responsive to the needs of older people, and offered home visits including domiciliary blood tests for those who were unable to attend the practice due to their clinical needs.
- The practice was accessible to patients with mobility difficulties and a wheelchair was available if needed.
- Flu and shingles vaccinations were available to patients in this age group.
- The practice met on a monthly basis as part of a multi-disciplinary team to discuss and review the care of those with end of life care needs.

# Summary of findings

**People with long term conditions**

Good

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

- Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Patients with long term conditions received a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Unplanned admission meetings took place monthly to review patients' needs and update care plans as necessary.
- The practice sought ways to improve attendance for health reviews for example, those with respiratory conditions were being recalled earlier in the year to avoid winter when there were higher levels of illness. Text messaging was being explored to try and communicate with patients who did not attend to identify any potential issues. Audits had also been undertaken during 2015 and 2016 to identify and actively follow up patients whose blood test results had indicated poor diabetic control but did not attend for a review. The audit had resulted in improved attendance (83% to 95%) and improvements in blood results for 11 out of the 16 patients actively targeted.
- Overall performance for diabetes related indicators (2014/15) was 97% which was higher than the CCG average and national average of 89%.
- The practice was participating in a heart failure project in conjunction with five practices to improve the management of patients at risk of heart failure. Patients at high risk were referred to heart failure nurses who helped support them in self-management. Of the 50 patients on the practice's heart failure register 32 have been seen by the heart failure nurse.
- The practice had sought to improve coding of patients at risk of developing diabetes so that these patients could receive better support and advice. Between 2014 and 2015 coding had improved from 58% to 96% based on blood results within the pre-diabetic range.
- Patients with chronic obstructive pulmonary disease (COPD) were given self-management plans which advised them what to do if experiencing specific symptoms.
- The practice offered a range of services to support the diagnosis and management of patients with long term conditions for example insulin initiation, electrocardiographs (ECGs), ambulatory blood pressure monitoring and spirometry.

# Summary of findings

**Families, children and young people**

Good

The practice is rated as 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, for example, children and young people who had a high number of A&E attendances or repeatedly failed to attend for child immunisations. Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours with both GPs and nursing staff and the premises were suitable for children and babies.
- The practice routinely met with the health visitor to discuss the needs of children at risk and carried out child health surveillance checks.
- A range of contraceptive services were available at the practice including the fitting of intra-uterine devices.

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

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services (for booking appointments and ordering repeat prescriptions).
- A range of health promotion and screening that reflects the needs of this age group were available. Patients could access NHS health checks and patient uptake of national screening programmes was high.
- Extended opening hours were available once a week on alternate Wednesday and Thursdays to support those who worked, this included appointments with both GPs and nurses.

**People whose circumstances may make them vulnerable**

Good

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

- The practice held register of patients living in vulnerable circumstances such as patients with a learning disability.

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- Annual health checks for patients with learning disabilities were undertaken by the Advanced Nurse Practitioner, 68% were completed within the last 12 months. The practice offered longer appointments for patients with a learning disability.
- Patients on the learning disability registered received patient passports which enabled them to record important information including likes and dislikes should they move between services.
- Information was available that informed vulnerable patients and those with caring responsibilities about how to access various support groups and voluntary organisations.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Practice staff told us that they had protocols in place for patients with no fixed abode to obtain care and treatment at the practice.
- We received several comments from patients and their carers of compassionate care they had received at times when they had been vulnerable. For example in the provision of end of life care, patients with learning disabilities and with poor mental health.

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

Good

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

- Nationally reported data for 2014/15 showed 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was slightly below the CCG average 82% and national average 84%.
- National reported data for (2014/15) showed 94% of patients with poor mental health had comprehensive, agreed care plan documented, in the preceding 12 months which was above to the CCG average 89% and national average 88%.
- The practice had a named nurse for mental health reviews.
- The practice was able to signpost patients to support services.

# Summary of findings

## What people who use the service say

The latest national GP patient survey results were published in January 2016. The results showed the practice was performing well compared with local and national averages. 268 survey forms were distributed and 121 (45%) were returned. This represented approximately 1.6% of the practice's patient list.

- 72% of patients found it easy to get through to this practice by phone compared to the CCG average of 62% and the national average of 73%.
- 82% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 69% and the national average of 76%.
- 83% of patients described the overall experience of this GP practice as good compared to the CCG average of 83% and the national average of 85%.
- 81% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 32 comment cards which were all consistently positive about the standard of care received. Patients described the service and staff as excellent. They told us that they were treated with dignity and respect by all staff. Some patients gave examples of compassionate care that they had received during difficult times.

We spoke with 12 patients during the inspection, including the chair of the patient participation group (PPG). All the patients were positive about the care they received, they told us that they were able to obtain appointments when they needed one and that staff were polite, caring and helpful.

# Tudor Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor and an Expert by Experience.

## Background to Tudor Practice

The Tudor Practice is part of the NHS Birmingham Cross City Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice is registered with the Care Quality Commission to provide primary medical services. The practice has a general medical service (GMS) contract with NHS England. Under this contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care.

The practice is located in a suburban area of Birmingham with a list size of approximately 7,500 patients. The premises are purpose built for providing primary medical services and co-owned and shared with another practice. There are also private consulting suites located within the premises.

Based on data available from Public Health England, the practice is located in an affluent area and is within the top 20% of the most affluent areas nationally. The practice population is predominantly white British. Compared to the national average the practice population had a higher proportion of patients over the age of 40 years and less patients aged between 20 years and 40 years than the national average.

Practice staff consist of four partners (two male and two female), four nurses (including one nurse practitioner), one health care assistant, a practice manager and a team of administrative staff.

The Tudor Practice is open from 8am to 6.30pm Monday to Friday. In addition the practice opens 6.30pm to 8.30pm one day each week (alternating between a Wednesday and Thursday evening) for extended opening. Appointment times vary between the clinical staff but usually ranged from 8.30am to 12.30pm and 2.30pm to 6pm. When the practice is closed services are provided by an out of hours provider (BADGER).

The practice is a training practice for qualified doctors training to become GPs and a teaching practice for final year medical students.

The practice has not previously been inspected by CQC.

## 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. The 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.

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 June 2016. During our visit we:

- Spoke with a range of clinical and non-clinical staff (including the GPs, practice nurses, the practice manager and administrative staff).
- Observed how people were being cared.
- Reviewed how treatment was provided.
- Spoke with health and care professionals who worked closely with the practice.
- Spoke with patients (including a member of the practice's Patient Participation Group).
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed documentation made available to us for the running of the practice.

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 were provided for specific groups of people and what good care looked 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).

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.

Good

# Are services safe?

## Our findings

**Safe track record and learning**

There was an effective system in place for reporting and recording significant events.

- Staff we spoke with were aware of the processes for recording incidents and told us that they would inform the practice manager of any that occurred. Staff were able to share examples of reported incidents and actions taken for example, a recent incident involving the cold chain.
- Systems in place supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Staff told us that when things went wrong with care and treatment, patients were contacted by a GP and offered an opportunity to discuss the incident.
- The practice carried out a thorough analysis of the significant events and discussed action required through weekly clinical meetings.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed with staff. The practice reported 14 significant events during 2015/2016. We saw evidence that lessons from these were shared with staff and more widely with other practices through the local clinical network. Annual meetings took place to review significant events which enabled any trends to be identified and ensured action had been implemented.

There was a designated lead GP for managing and actioning safety alerts. Safety alerts were routinely discussed at weekly clinical meetings. Records were maintained to show that these had been acted on. In one example patients on a particular medicine had been contacted to discuss information received through a safety alert.

**Overview of safety systems and processes**

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Safeguarding policies and information which clearly outlined who to contact for further guidance in relation to concerns about a patient's welfare were accessible to all staff. There were lead members of staff for safeguarding. Staff demonstrated they understood their responsibilities and received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three. Alerts placed on patient records ensured staff were aware if patients were at risk and information from safeguarding meetings with health visitors were shared with relevant staff so that they were aware.
- Notices were displayed in the waiting room which advised patients that chaperones were available if required. Only clinical staff acted as a chaperones. Those who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Cleaning schedules were in place for rooms and equipment. The practice manager undertook regular environment checks and recorded any issues in a communication book for the cleaning staff to address. Staff had access to cleaning and personal protective equipment. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There were infection control policies and procedures in place and staff had access to online training. The CCG had undertaken an infection control audit in December 2015 in which the practice had scored 90%. We saw evidence that action was being taken to address improvements identified as a result. Appropriate arrangements were in place for the disposal of clinical waste including sharps such as needles.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions for those with long term conditions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of

the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Uncollected prescriptions were checked regularly by a GP. Some of the nurses had qualified as an Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received support from GPs and told us that they only prescribed within their area of expertise and any changes to medicines were always done by a GP. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistant were trained to administer vaccines and medicines against a patient specific direction from a prescriber. We saw that medicines held in the practice were stock rotated and those looked at were in date.

- We reviewed four personnel files (including one locum staff) and found 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 checks through the Disclosure and Barring Service.

**Monitoring risks to patients**

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The premises appeared well maintained. Health and safety checks were undertaken on a monthly basis.
- The practice had up to date fire risk assessments and carried out regular fire drills to ensure staff knew what to do. The practice had a trained fire marshal and staff received fire safety training as part of their induction. We saw evidence that fire equipment was regularly serviced and alarms tested on a weekly basis.
- Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Testing had been undertaken within the last 12 months.
- A legionella risk assessment had also been carried out on the premises. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staffing rotas were discussed at the weekly clinical meetings to ensure appropriate cover was in place and a buddy system operated during holidays to ensure important tasks were completed.

**Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen (with adult and children's masks), routine checks were undertaken to ensure these were in working order and ready for use when needed.
- Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew of their location. All the medicines we checked were in date and stored securely. Records of checks undertaken were maintained.

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 and various services that might be needed. Staff we spoke with were aware of the plan and told us that they had recently used it when telephone lines had been affected by heavy rain. There was a reciprocal agreement with another local practice to use their premises should the practice's own become inaccessible.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- We saw examples of clinical audits undertaken to check practice against NICE and local guidelines. For example, management of patients with atrial fibrillation and diabetes and local prescribing guidance for antibiotics.
- Clinical meetings were used as an opportunity to discuss patients with complex needs and we saw evidence of this from the minutes of meetings.
- Nursing staff told us that they attended regular updates which enabled them to keep up to date in their areas of expertise. They would also share information gained from courses attended with other members of staff.

**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). The most recent published results were for 2014/15. This showed the practice had achieved 98% of the total number of points available, which was higher than the CCG average of 94% and national average of 95%. The published QOF data did not include any exception reporting. Exception reporting is used to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. We asked the practice about this who told us they did exception report at the end of the QOF year and after sending three invites to the patients, so they were not sure why this was not reported. GPs were informed if patients with certain conditions did not respond to invites for review such as, patients with cancer or those on high risk medications. The practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- Overall performance for diabetes related indicators was 97% which was higher than the CCG average and national average of 89%.
- Overall performance for mental health related indicators was 100% which was higher than the CCG average of 92% and the national average of 93%.

There was evidence of quality improvement including clinical audit.

- The practice had a documented audit plan. They shared with us seven clinical audits that had been completed since 2015, four of these were completed audits where the improvements made were implemented and monitored. The remainder had dates scheduled for re-audit.
- Audits included a pre-diabetes audit which showed improvements in coding (58% in 2014 to 96% in 2016). This ensured patients could be identified and effectively managed in line with guidance.
- An antibiotic prescribing audit reported a 29% reduction (and improvement) in broad spectrum antibiotic prescribing between 2014 and 2015. The practice had actively sought to reduce antibiotic prescribing and educate patients in their use.
- Prescribing data available showed prescribing for medicines such as antibiotics, hypnotics and non-steroidal anti-inflammatory drugs were comparable to other practices nationally.
- The practice has been involved in developing a successful scheme for reducing unplanned admissions and improving outcomes to patients in collaboration with two other practices. This had involved a comprehensive programme of redesign and networking to obtain support and co-operation across organisational barriers. To date the scheme has resulted in a reduction of average number of hospital deaths by 90, 5800 hospital bed days saved and reduced admission spend by £1.2 million. As well as this they have participated in complementary schemes to support the self-management of patients at risk of heart failure by working with specialist teams and elderly patients to support and improve outcomes for them by identifying and responding to unmet demand.

Good

# Are services effective?

## (for example, treatment is effective)

### Effective staffing

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

- The practice had an induction programme for all newly appointed staff, including locum staff. These were role specific. We saw examples of the induction timetables for administrative staff.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nursing staff had undertaken additional training in areas such as respiratory conditions and diabetes.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. They also attended update sessions.
- Staff had access to training through e-learning and in-house training that included: safeguarding, fire safety awareness, basic life support and information governance.
- The practice maintained a file in reception of what it termed 'bite sized training'. Staff were encouraged to regularly review this file as it contained information to keep them informed for example on using SMS messaging.
- The learning needs of staff were identified through a system of annual appraisals and the needs of the service.

### 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. Staff responsible for scanning information onto patient records told us that they were up to date with this.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services and with the out of hours services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. Practice staff regularly met with other health care professionals to discuss patients with end of life care needs, those who had unplanned admissions and to discuss the needs of vulnerable children.

We saw positive examples of where the practice had worked in collaboration with other health and social care organisations for the benefit of patients, for example in reducing unplanned admissions and accident and emergency attendances.

### Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff told us they had received training in this.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. Clinical staff told us they would not refuse to see children alone.
- We saw that formal consent was obtained for minor surgery and the fitting of intrauterine devices which were carried out at the practice.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example patients receiving end of life care, carers, those at risk of developing long-term conditions and those requiring advice and support in relation to their lifestyle.

- Staff were able to refer patients to health trainers who gave lifestyle support for example, diet and exercise advice.
- The practice operated specialist clinics to review and monitor patients with specific long term conditions such as diabetes, heart failure and respiratory conditions. Patients we spoke with confirmed they received regular reviews of their condition.
- We saw examples of self-management plans to support patients with conditions such as chronic obstructive pulmonary disease and heart failure which advised them what to do if experiencing specific symptoms.

Good

# Are services effective?

## (for example, treatment is effective)

- Leaflets around the practice and information on the practice websites was available to help patients understand their care and treatment.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 78% and the national average of 82%. There were systems in place to follow up patients who did not attend for their cervical screening test and for ensuring results were received for samples sent for the cervical screening programme. The practice followed up women who were referred as a result of abnormal results.

Uptake of national screening programmes such as breast and bowel cancer screening was higher than both the CCG and national averages. We saw information in the patient newsletter promoting the breast screening service.

Childhood immunisation rates for the vaccinations given were higher than the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 100%, compared to the CCG average of 80% to 95% and five year olds from 87% to 100%, compared to the CCG average of 86% to 96%.

Flu and shingles vaccinations were offered to relevant patients.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Patients we spoke with confirmed that they had been offered these health checks and 159 had been completed so far this year.

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 consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Clinical rooms were locked by keypad system to minimise the risk of unauthorised access during a consultation.
- To help minimise the risk of patient conversations with staff from being overheard, music was played in the waiting area and a barrier was set up to encourage patients to stand back from reception.
- Staff wore name badges so that it was clear to patients who they were speaking with.
- Staff were aware of their responsibilities for patient confidentiality and knew what they needed to do to ensure patient information was kept secure.
- The practice produced newsletters in conjunction with the patient participation group to help keep patients informed about what was going on in the practice, for example text messaging to confirm and cancel appointments.

Feedback from patients received through the 32 patient Care Quality Commission comment cards and the 12 patients we spoke with in person was very positive. Patients repeatedly told us the service was excellent, that staff went that extra mile, that the service was efficient, professional, friendly and caring. All staff groups were spoken highly of. We received comments about the kindness and compassion shown to patients who were at the end of life, with poor mental health and with learning difficulties. Patients told us they were treated with dignity and respect. There were no negative comments.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable for its satisfaction scores on consultations with GPs and nurses. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG and the national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.
- 85% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 91%.
- 89% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

The practice had undertaken its own in-house patient survey during October 2015 and January 2016 of 144 patients. Results from this was also positive with 93% of patients who responded rating the service overall as good or better than good.

**Care planning and involvement in decisions about care and treatment**

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

We saw that personalised care plans were in place for the practice's most vulnerable patients with long term conditions and complex care needs and that results from health reviews for long term conditions were shared with patients.

Patients on the practice's learning disability register were given the opportunity to complete patient passports which recorded important information about them should they move between services. This included information about their preferences so that they could be taken into account.

Good

# Are services caring?

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. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and the national average of 82%.
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language but had not needed to use it.
- The practice held information leaflets in easy read format on issues such as breast screening and testicular cancer.

**Patient and carer support to cope emotionally with care and treatment**

Patient information was available in the patient waiting area which told patients how to access various support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted staff if a patient was also a carer. The practice had identified 65 patients as carers (approximately 0.9% of the practice list). There was a carers form at reception to encourage patients to identify themselves to the practice and a prominent noticeboard with information for carers on various avenues of support available to them. The practice had identified two members of staff as carers buddies, they had developed a directory of support. With help from the PPG the practice had held a carer support day to provide advice to carers.

Staff told us that families who had suffered bereavement would be contacted and signposted, as appropriate, to support available. Practical advice on what to do in the event of death and signposting to local bereavement services was also available on the practice website.

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice was participating in the CCG led Aspiring to Clinical Excellence (ACE) programme aimed at driving standards and consistency in primary care and delivering innovation. One of the senior partners also had a lead role within the CCG.

- The practice had been instrumental in leading a successful project aimed at reducing unplanned admissions. The project which extended more widely than the local enhanced service for unplanned admissions included all patients over the age of 70. The scheme recognised the needs of the high elderly population and pressures faced by the local hospital. The practice was involved in facilitating service redesign which included extensive networking and co-operation of key stakeholders to ensure the success of the project. It started as a collaboration with two other practices approximately 18 months previously and due to the significant benefits achieved it had recently been expanded to six practices (and a population of 64,000 patients). An analysis of the scheme has shown positive impact on both patients and secondary health care, including reductions in hospital mortality rates compared to non-participating practices, reductions in average length of hospital stay and costs. For the practice this has meant 90 less hospital deaths, 5800 hospital bed days saved and reduced admission spend by £1.2 million. The senior partner explained the considerable time, effort and investment involved in setting up the project and infrastructure in order to ensure the success of the project. They had sought to understand patient experiences and those of health and social care stakeholders involved in supporting patients following hospital discharge to understand the challenges they faced. The project sought support from a service redesign consultant and employed initially two (now three) community matrons to facilitate safe patient discharge. There was development of supporting IT systems to enable primary care staff to receive live data on patient admissions as well as networking and other events to develop strong and robust relationships and joint working between primary and secondary care and a range of other stakeholders. This was fundamental in ensured the smooth running of the scheme and safe discharges. The impact collectively from participating practices (as at May 2016) includes a fall in hospital readmissions by more than 6 admissions on average each week and the facilitation of early safe discharge for over 200 patients. The project is maintained through weekly meetings to discuss the patients care needs and continuing support. A purpose built secure website was regularly updated by the senior partner of the practice to ensure important information was shared.
- Complementing the unplanned admission scheme, the practice was also participating in three other local schemes including:The elderly care support nurse pilot project reviewing all patients over 75 years on the practice list to identify, assess and help address any unmet care and support needs. Over 300 patients from across the six participating practices have benefited to date receiving care and support from a range of services including NHS, local authority, third sector and voluntary organisations .

A heart failure project in conjunction with five practices in the local area as part of the ACE scheme. The project aimed to improve the management of patients and work more closely with heart failure nurses and clinicians to reduce admissions. Patients at high risk were referred to the heart failure nurses. Of the 50 patients on the practice's heart failure register 32 had received specialist support with self-management plans.

An ambulance triage scheme in which the GPs provide advice to paramedics and facilitate support for patients within primary care as an alternative to accident and emergency.

- There were longer appointments available for patients with a learning disability or poor mental health. Practice staff had a flexible approach to appointments to ensure those who were difficult to reach could still get the care they needed.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. The practice did not offer yellow fever but were able to signpost patients to clinics that did.
- The practice was accessible to patients with mobility difficulties, we saw patients who used wheelchairs were able to access consulting rooms during our inspection. A wheelchair was also available onsite for anyone who needed to use it. There were disabled parking and toilet facilities.
- A hearing loop and translation services were available. The practice had also obtained consent from patients so that they could speak with a named relative where communication was difficult over the telephone.
- There was a self-check in which avoided the need for patients to queue at reception.
- The Advanced Nurse Practitioner ran a daily urgent care clinic (overseen by the duty doctor), they were able to see patients with a variety of conditions. A list of these was available at reception.
- Private outpatient clinics operated from the premises in specialities such as Ears Nose and Throat (ENT), rheumatology, ophthalmology and plastic surgery. These were also available to NHS patients through the choose and book system. This provided greater options and convenience for patients who were able to see consultants closer to home for their outpatient appointments.

**Access to the service**

The practice was open between 8am and 6:30pm Monday to Friday. Appointment times varied between the clinical staff but usually ranged from 8.30am to 12.30pm and 2.30pm to 6pm. Extended hours appointments were offered one evening each week (alternating between Wednesday and Thursday 6.30pm to 8:30pm). In addition to pre-bookable appointments that could be booked approximately six to seven weeks in advance, additional appointments were released for face to face consultations and telephone triage each day for those with more urgent needs. We saw that the next available routine appointment with a GP was available on the day of our inspection and the next available appointment for a blood test was within one working day of our inspection.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to national averages and above local averages.

- 77% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and the national average of 78%.
- 72% of patients said they could get through easily to the practice by phone compared to the CCG average of 62% and the national average of 73%.

Feedback we received from patients in person and from our comment cards told us that they usually found it easy to obtain an appointment when they needed one.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice had trialled and implemented an appointment system which included a combination of routine appointments and triage for urgent needs. Monday and Friday being the time of greatest demand operated the triage system for appointments only. For the rest of the week the practice operated both pre-bookable appointments and urgent triage appointments.

The practice had undertaken its own in-house patient survey during October 15 and January 2016 of 144 patients. The practice had asked patients about the triage system 49% had found the triage system very or extremely useful.

The practice recognised that telephone lines could be busy in the morning and operated a general enquiries line for non-appointment and prescription enquiries to take the pressure off reception. The line was operated by a member of the administrative team away from the reception area.

**Listening and learning from concerns and complaints**

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a complaints leaflet for patients to take away and

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

information was also available on the practice's website. The complaints leaflet detailed how patients could escalate their complaint if they were unhappy with the practice's response.

During April 2015 to March 2016 the practice had received 14 complaints. We found complaints were handled appropriately. Lessons were learnt from individual concerns and complaints and also from analysis of trends. An annual meeting was held to review complaints received and share any learning from them.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice shared with us their vision and strategy for the future in which they were working to develop a partnership with four local practices where central functions and resources would be shared. It was anticipated that through this merger they would be able to provide a wider range of services to patients.
- The practice was already working collaboratively with these practices to develop innovative schemes to improve patient experiences and deliver benefits to the health economy.
- The practice was also a member of 'Our Health Partnership' consisting of 32 practices to help respond to the changing demands faced by GP practices.
- Staff understood the values of the practice and worked well as a team to ensure patients received safe and effective care.
- The practice had a mission statement which was displayed in reception.

**Governance arrangements**

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff via their computers.
- A comprehensive understanding of the performance of the practice was maintained. The practice performed well against QOF and other national indictors of patient outcomes. Staff attended local clinical network meetings. There were designated members of staff responsible for checking QOF data and contacting patients for their annual reviews.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements with learning shared with clinicians.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

**Leadership and culture**

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The practice was able to demonstrate that they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and took the time to listen to them. The practice was well organised and information well documented for future reference.

The senior partner commented how it was through the continued support of their colleagues that they had been able to invest time and resouces into the development of the unplanned admission scheme to improve patient outcomes.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment people received reasonable support, truthful information and an apology

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

- Staff told us the practice held regular practice meetings.
- Clinical meetings actively provided learning opportunities for staff.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at practice meetings and felt confident and supported in doing so, specific slots on the agenda were available for each staff group.
- The practice held regular events for all staff in which the practice closed for half a day (there had been two so far during 2016). This provided opportunities for training and team building.
- Staff said they felt respected, valued and supported, by the partners and senior staff in the practice. For example, staff had been involved in discussions about the new partnerships taking place and had opportunities to raise questions about what it would mean for them.
- We found the practice to be well organised.

# Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG consisted of approximately 10 active members which met regularly with the partners, information on the practice website invited patients to join the group. The practice undertook annual patient surveys. The latest results were positive. However, in response to feedback the practice had reviewed and made changes to the appointment system to improve access. For example, the introduction of a triage system.
- The practice had gathered feedback from staff through staff and team meetings, appraisals and general discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, and we saw examples of this in the clinical meetings. Nursing staff told us how they raised issues about the way in which patients were recalled for respiratory conditions which meant that those called during winter were often less well. The system was now being changed to do all the reviews, where possible, at other times during the year.

**Continuous improvement**

There was a focus on continuous learning and improvement at all levels within the practice. Practice staff were well supported in their professional development.

The practice was forward thinking and was a key player in service redesign in the local area to help manage unplanned admissions. They worked well in collaboration with other practices to develop such schemes and were able to demonstrate significant benefits as a result. The practice was also proactive in identifying and participating in schemes that had been successfully implemented elsewhere in the CCG which would also benefit their patients.

The practice was a training practice for qualified doctors training to be a GP and a teaching practice for medical students. We saw positive feedback about the support received from those who had been placed at the practice.