Hereward Group 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?	Good
Are services well-led?	Good

Summary of findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as good overall (at the previous inspection undertaken in 12 October 2016, the practice received a good overall rating).

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Hereward Group Practice on 28 February 2018 and 27 March 2018. This inspection was carried out 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 was 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.

At this inspection we found:

- There was a structured approach to risk within the practice and this was well managed by the leadership team.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- GPs and practice staff worked effectively as a cohesive team and provided personalised and responsive care to their patients.
- There was a walk in surgery on Monday mornings and extended hours every Saturday morning to alloy for flexibility in the way appointments were available.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- In response to some GPs leaving employment with the practice, there was the introduction of an 'Acute Illness team', which increased the number of appointments and allowed for the reception team to book the most appropriate clinician for the patients need.
- There was a clear leadership structure and staff told us they felt well supported by the partners and practice manager. We observed the positive impact this had in establishing a well-integrated practice team.

Summary of findings

We saw the following areas of outstanding practice:

- The practice had implemented a quality management system to ensure each part of the practice was achieving the required standards.

However there were areas of practice where the provider should make improvements:

- Review the levels of patient satisfaction, and continue to improve in relation to access to the service.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Hereward Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**. On the initial inspection (**28 February 2018) **t**he team also included a practice manager specialist advisor. This was followed up with a second inspection (27 March 2018) due to the poor weather conditions during the first visit, also led by a CQC inspector this included a GP specialist advisor.

Background to Hereward Group Practice

Hereward Group Practice (www.herewardgp.co.uk) provides primary medical services to approximately 12,600 patients.

The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Hereward Group Practice is a two storey building situated in Bourne, Lincolnshire. It has car-parking facilities with spaces for patients with a disability. The practice has automatic doors at the entrance. Toilet facilities are available which includes disabled access.

The practice provides dispensary services to 29% of those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy. The practice also provides a delivery service and has four medicine collection points where patients can collect their medicines.

The practice team consists of five GP partners (one female and four male), two salaried female GPs, and one GP registrar. The practice employed three nurses, two paramedics and two-advanced nurse practitioners working with five health care assistants. The clinical team work alongside a practice manager, an assistant practice manager and a team of administration and reception staff.

The practice is located within the area covered by South Lincolnshire Clinical Commissioning Group (CCG). The CCG is responsible for commissioning services from the practice. A CCG is an organisation that brings together local GP's and experienced health professionals to take on commissioning responsibilities for local health services.

We inspected the following location where regulated activities are provided:-

Hereward Group Practice, Exeter Street, Bourne, Lincs. PE10 9XR

The practice is open between 8am and 6.30pm Monday to Friday. A range of GP appointments are available from 8.40am to 5.40pm Monday to Friday. Nurse Appointments from 8.40am to 6pm Monday to Friday and Health Care Assistant from 8am to 4.30pm Monday to Friday.

Extended hours appointments are offered on a Saturday morning from 8am to 12 midday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

Hereward Group Practice had opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided by Lincolnshire Community Health Services NHS Trust.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments, including those for fire, Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings), and general health and safety issues. It had a range of safety policies which were regularly reviewed and staff received safety information as part of their induction and ongoing training programme.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. All staff received up-to-date safeguarding training appropriate to their role. The lead GP supplemented mandatory training with in-house talks so staff could be kept current and. Members of the practice team knew how to identify and report concerns.
- The practice team worked with other agencies to support and protect patients from abuse, neglect, discrimination and breaches of their dignity and respect. We saw clear evidence of effective working with community based health and social care staff to achieve this aim. For example, there were meetings every six weeks with health visitors and school nurses to review children who were at risk.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. A nurse was identified as the infection control lead for the practice. Annual audits were undertaken and any follow up actions that were identified were addressed promptly. The lead took time with new staff to identify key infection control themes as part of their induction, and took charge of any significant event regarding an infection control issue. There was a meeting every three months for local infection control leads who were able to get updates and review areas of concern which the lead disseminated to staff during team meetings.
- There were systems in place to support the safe management of healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- The practice had implemented a quality management system to ensure each part of the practice was working in line with required standards. Monthly self-audits and external audits, completed by another team, ensured everything was up to date, all actions completed and risks and alerts had been dealt with appropriately.

This was completed by issuing a set of quality management system questions to each department with a monthly rolling program of self and external audits. A risk register was then populated to ensure information, held on risk, was current. Staff told us that leads benefited from a structured set of objectives to maintain standards in the practice.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction programme for staff tailored to their role. This was followed up with a period of mentorship and ongoing support.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The duty GP was stationed behind reception to assist in identifying patients who may present with urgent conditions and triaged patients to the correct clinician.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Good

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. Information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.
- The practice had systems to ensure that any urgent incoming patient documents and pathology results were reviewed and actioned appropriately.

Safe and appropriate use of medicines

- The systems for managing medicines, including emergency medicines and equipment minimised risks. There was a documented process for checking emergency medicines and ensuring they were fit for use.
- Patients receiving high risk medicines were monitored appropriately to ensure it remained safe to continue their prescriptions.
- Standard Operating Procedures (SOPs) were in place to govern procedures within the dispensary.
- The practice had a process for identifying and reviewing significant events, which included those within the dispensary. All complaints were raised as significant events and run through the process to ensure all learning was ascertained.
- Vaccines and medical gases were effectively managed.

Lessons learned and improvements made

- There was a system for recording and acting on significant events, incidents and near misses. There had been 26 significant events had been recorded in the preceding 12 months. An annual review was conducted to ensure the process had been completed for all events and trends recognised, external partners were involved in the process as necessary.
- Staff understood their duty to raise concerns and report incidents. Leaders and managers supported them when they did so, and encouraged reporting.
- Learning outcomes and actions were documented and the effects these had were monitored to measure how effective changes were in reducing the likelihood of a future recurrence.
- An annual review of incidents was undertaken in discussion with the practice team to review any themes and discuss the outcomes achieved collectively.
- There was a system for receiving and acting on patient and medicine safety alerts. We saw evidence that when medicines alerts were received, searches were undertaken to identify patients this might affect, and these were then followed up and reviewed accordingly. A log was kept to allow partners to review any outcomes of alerts. All alerts were discussed every two months between the Partners and practice manager to review the actions identified and ensure they were followed through to completion.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clinical pathways and protocols. Clinicians were able to describe examples of recent discussions held in relation to new or updated guidance.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support, if external providers were more suitable.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs, including a review of their prescribed medicines.
- All patients over 65 had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs and practice nurses also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- Interim reviews were conducted as appropriate, for example, patients with poorly controlled diabetes were seen by the practice nurses more regularly to support their condition.
- The practice provided an in-house phlebotomy (taking blood) service.
- For patients with the most complex needs, the practice team worked with other health and care professionals, including specialist nurses, to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions, had received specific training in support of this. We spoke to proactive and motivated practice nurses who specialised in long term conditions they were passionate about and went the extra mile to ensure all patients were reviewed.

Families, children and young people

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- We found there were systems to identify and follow up children living in disadvantage circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Meetings were held with the health visitor and school nurse every six weeks to review any children where there were any known safeguarding concerns.
- The practice provided emergency contraception, and offered family planning services.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on a Monday evening and Saturday morning appointments.
- The practice's uptake for cervical screening was 81%, which was below the local average of 83% and in line with the national average of 81%. This was achieved with a lower exception reporting rate, below the local and national averages. This outcome contributed to the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

People whose circumstances make them vulnerable:

Good

Are services effective?

(for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice worked with voluntary services, to enhance the support available to their most vulnerable patients.
- End of life care was delivered in a coordinated way with extensive collaboration from the multi-disciplinary team via weekly meetings and regular communication in-between. The care provided took into account individual needs such as the patients preferred place of care.
- The practice had identified patients as carers. The carers were offered advice and could be signposted to sources of additional support if they consented to this.

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

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was marginally lower than the local average of 85% and national average of 84%. Exception reporting rates were below averages.
- 83% of patients with a new diagnosis of dementia recorded in the preceding year had a record of recommended investigations recorded between 12 months before, or 6 months after, entry onto the practice register. This was below the CCG average (90%) and national average (87%), although exception reporting rates were significantly higher at 40% which was 5% more than the CCG rate and 17% above the national average.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was below the local averages of 96% and above the national average of 90%. Exception reporting rates were higher at 18% (7% above the CCG average, and 6% above the national average), but this was due to the small number of patients this indicator applied to.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, there was a documented clinical audit plan which included the monitoring of some high risk medicines, and for reviews of patients with conditions such as diabetes and atrial fibrillation.

The most recent published Quality Outcome Framework (QOF) results for 2016-17 were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 99% and national average of 96%. The overall exception reporting rate at almost 8% was in line with the local average, and approximately 2% above the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

- The practice employed a data quality lead to monitor performance, they drove action by communication with clinicians, highlighting patients who were due for a recall as well as initiating recalls them self.
- The practice was involved in quality improvement activity and provided a timetable of their internal audit programme. We reviewed a completed full cycle clinical audit which was to assess the number of patients on a medicine to manage their diabetes to ensure they were prescribed in line with guidance and that patients continued to have good renal function. The latest audit showed only one patient out of 31 who had received a higher dose of the medicine. They were recalled and their care reviewed. As a result of the audit, all 'at risk' patients notes were labelled with a pop up reminder to help prescribers in reviewing doses.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Records of training were maintained and monitored via a practice training matrix, which included defined

Good

Are services effective?

(for example, treatment is effective)

recommended intervals for further update training. We saw that staff were up to date with training and all essential training had been completed. Staff told us they were encouraged and given opportunities to develop.

- The practice provided staff with ongoing support. This included an induction process, regular meetings, appraisals, and support for revalidation. The 'Acute Illness Team' informed us that they met the lead GP regularly and would discuss case studies for clinical supervision and mentorship.
- There was an approach for supporting and managing staff when their performance was poor or variable. Staff were aware of the whistleblowing process.
- Locums were rarely used and when they were they would be sourced from those who had previously worked at the practice. This ensured familiarity with systems and continuity for patients and staff. The practice generally used the same GP to cover any available locum sessions.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The practice team worked effectively with community-based staff as part of an integrated approach to care.
- The development of the 'Acute Illness Team' comprising of two paramedics and two nurse practitioners was a solution to the lack of appointments following two GPs leaving the practice. This had increased capacity and provided appointments to adults and children with acute illness or minor injuries. There were strict protocols in place for the assignment of patients to these clinicians depending on conditions and the duty doctor was available to support consultations if necessary.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Patients with end of life care needs were reviewed at the weekly multi-disciplinary meetings which usually included attendees from the local hospice and Macmillan nurses.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, there was access to smoking cessation advice on site.
- NHS Health checks were available for patients aged 40-74 years old.
- Uptake rates for breast and bowel cancer screening was above national averages and slightly higher than local rates. For example, three year coverage breast screening rates for females aged 50-70 was 83% (CCG 78%; national 70%), and two and a half year coverage for bowel cancer screening in 60-69 year olds was 64% (CCG 61%; national 55%)

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Patients told us that staff treated them with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room next to reception to discuss their needs.
- All of the73 Care Quality Commission patient comment cards we received were positive about the service experienced. Patients praised individual staff at all levels for providing good care and support. The overall view from the comment cards was positive.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 222 surveys were sent out and 124 were returned. This represented about 1% of the practice population. The practice was in alignment with CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 96%; national average - 95%.
- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 90% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 87% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 87% of patients who responded said the nurse was good at listening to them; (CCG) - 91%; national average - 91%.
- 86% of patients who responded said the nurse gave them enough time; CCG – 92%; national average - 92%.
- 92% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 97%; national average - 97%.
- 86% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 77% of patients who responded said they found the receptionists at the practice helpful; CCG - 88%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- There was a comprehensive website, which explained the service and the roles of the staff.
- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aids (such as a hearing loop) and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers, and the list was reviewed on a regular basis to ensure it was kept updated. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 410 patients as carers, which was 3.2% of the practice list.

- The practice was working towards the 'Lincolnshire Carers Quality Award' and staff had attended carer awareness training.
- There was a comprehensive presentation in the waiting room organised by the carers lead to encourage new carers to come forward and support existing carers.
- Staff told us that if families had experienced bereavement, a member of the practice team would usually try and contact the family or carer. This call may either be followed by a patient consultation (if required) and/or by giving them advice on how to find a support service.

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:

- 86% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.
- 88% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 76% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 84%; national average - 85%.

Privacy and dignity

- Staff recognised the importance of patients' dignity and respect and promoted this through all aspects of their work. This was integral within the practice culture and reflected within the practice values.
- The practice complied with the Data Protection Act 1998, and all staff were up to date with training in information governance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

- The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.
- The facilities and premises were appropriate for the services delivered. All patient services were delivered from the ground floor which were easily accessible by wheelchair.
- The practice understood the needs of its population and tailored services in response to those needs. For example, extended opening hours were available on a Saturday morning and Monday evening; online services were offered such as repeat prescription requests; and advanced booking of appointments could be made.
- The practice made reasonable adjustments when patients found it hard to access services. The practice provided patients with information they required in the format that they required, for example, in larger print.
- The practice provided a wide range of information leaflets for patients.

Older people:

- All patients over 75 had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- Care homes had a designated GP who visited every six months to review all patients in addition to booked appointments.
- If patients received their medicines from the practice's dispensaries, these were delivered to the patients homes up to twice a week if they were unable to collect them.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Longer appointments were available.
- There was a protocol in place to assist staff identify patients with frailty which triggered more regular reviews.
- Flu clinics were run during winter months as well as shingles and pneumococcal vaccinations. Flu clinics were combined with a 'pulse check' to identify anyone with atrial fibrillation.

People with long-term conditions:

- A GP was the palliative care lead and they attended monthly meetings with the local palliative care nurses and a local end of life home.
- Patients with a long-term condition received an annual review by a practice nurse specialising in the relevant condition, to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- There was a 'self-service' blood pressure monitor available for patients with hypertension to use themselves to monitor their blood pressure. Reception staff would then record this in the patient care record. There was a protocol in place for unusually high readings to be passed to the duty doctor for review.
- The practice held regular meetings and worked with community based teams to discuss and manage the needs of patients with complex medical issues.
- For patients on high risk medications which required blood tests but were unable to get to the practice, nurses would visit the patients in their own homes.
- The practice worked closely with specialist nurses, for example, diabetes specialist nurses, to provide expert advice for those patients that required it.

Families, children and young people:

- The practice provided contraception services and operated the 'c-card' service. (The aim of the c-card service is to promote reproductive and sexual health and help young people to access local services).
- Several doctors offered coil and implant fitting and removal at the practice.
- Nurses administered all child immunisations and followed up on those who patients who had missed any due immunisations.
- The practice had aligned access to make it easier for families, children and young people to see a clinician. For example there was a Monday morning walk in surgery, and the 'Acute Illness Team' were able to see adults and children with acute illnesses and minor injuries in addition to GP appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The safeguarding lead attended monthly meetings with the health visitor and school nurse to review children at risk.
- The practice had easy access for people with prams and there was a baby changing facility. Breastfeeding was welcomed at the practice.
- All children were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, pre-bookable extended opening hours appointments were available on a Saturday morning and a Monday evening.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The 'Acute Illness Team' offered clinics every day to provide on the day access for patients with acute illness and minor injuries.
- Healthcare assistants offered early morning blood appointments for those who worked during the day and were unable to attend.
- A GP provided minor surgery clinics at the practice reducing the need for secondary care referrals.
- There was an in-house physiotherapy service provided by a third-party to improve access to the service.
- The dispensary delivery driver delivered medication to four village post offices so patients who were at work during the day could pick up their medicines at a convenient location to them.
- Patients could have their medicines delivered to their home address through a third party service.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- A new telephone system had a shortcut button which directly linked staff with a telephone translation service.
- There was a telephone loop for those who had a hearing aid.
- A GP carried out learning disability health checks to ensure continuity and alerts were put on patient care records to make staff aware of this.
- The practice welcomed people living in vulnerable circumstances, such as homeless people to register with the practice.
- GPs referred patients with alcohol and substance misuse to 'Addaction' for additional support outside the practice.

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

- Key staff had undertaken Dementia awareness training to make them more able to identify and support patients with dementia.
- A pop up reminder was added to the records of those who have memory problems to enable reception staff to take extra care when making appointments or giving information over the phone.
- Counsellors were available in house making it less stressful for patients to access the service.
- All patients with a past medical history of severe mental illness received an annual mental health check by a GP.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.
- A monitoring system for all incoming calls was prominently displayed in the reception office and the practice manager's office. This allowed other staff to assist colleagues when there was a high volume of calls to keep the waiting time for patients down.
- The appointment system was easy to use. The practice offered pre-bookable appointments for non-urgent cases. Each day some appointments were released as 'book on the day' to accommodate those patients who felt they needed to be seen and could not wait for the next available appointment. When the day's appointments were fully booked, a telephone triage system was used to review patients and when necessary, arrangements were made to see them in person that day.
- Telephone consultations with the duty doctor were also used for advice, and patients could book these directly.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they

Good

Are services responsive to people's needs?

(for example, to feedback?)

could access care and treatment were either in line with or slightly below local and national averages. A total of 222 surveys were sent out and 124 were returned. This represented 1% of the practice population.

- 51% of patients who responded said they usually got to see or speak to their preferred GP; CCG - 63%; national average - 56%. On the day of our inspection, we saw that a routine appointment with a GP of the patient's choice could be booked in 9 days' time.
- 67% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 73% of patients who responded said they could get through easily to the practice by phone; CCG – 74%; national average - 71%.
- 86% of patients who responded said that the last time they wanted to speak or see a GP or nurse; they were able to get an appointment; CCG - 88%; national average - 84%.
- 37% of patients who responded said they usually waited 15 minutes or less after their appointment time to be seen; CCG - 67%; national average - 64%.
- 63% of patients who responded described their experience of making an appointment as good; CCG - 77%; national average - 73%.

These results were supported by patient feedback received via completed comment cards. Out of the 73 cards we received, all included positive comments about individual patient experience. Five of the cards included an additional negative remark about difficulty in getting an appointment, with two stating that appointments often ran late.

We saw from minutes of meetings that access to appointments was discussed and made reference to an increasing demand for appointments. The 'Acute Illness Team' were one solution to this and feedback from future data would be reviewed to see if there this had led to an improvement for patients.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The practice's complaint policy and procedure was in line with recognised guidance. There had been 14 complaints received over the preceding 12 months. We reviewed two of these and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual complaints and also from analysis of trends via an annual practice complaints review. It acted as a result to improve the quality of care.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience and skills to deliver the practice strategy.
- The partners and practice manager were knowledgeable about issues and priorities relating to the quality and future of services.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Staff had specific lead responsibilities such as prescribing, QOF and safeguarding.

Vision and strategy

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

- The practice had developed its mission statement with a clear focus on delivering safe, efficient, high quality patient care. Partners and managers portrayed their commitment to achieve this.
- Staff were aware of and understood the vision, the mission statement and future strategy and their role in achieving them.
- The practice held business planning meetings and partnership meetings.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued, and told us that they enjoyed their work in the practice.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were positive relationships between practice staff and community based teams.
- The practice demonstrated openness, honesty and transparency when responding to incidents and complaints. The provider was aware of, and had systems to ensure compliance with the requirements of the duty of candour. We saw evidence to confirm this when reviewing incident reports
- The practice culture prioritised the needs of patients.
- There were processes for providing all staff with the development they need. In the last year, all staff had received an annual appraisal. Staff told us they were supported to undertake training which would benefit the patients and meet the requirements of professional revalidation where necessary.
- There was a practice equal opportunities policy and staff were encouraged to undertake equality and diversity training. Staff we spoke with on the day of the inspection all felt that they were treated equally.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended such as the quality management system for all departments.
- There was a schedule of regular in-house meetings, including quarterly clinical meetings and full staff meetings which usually took place each month.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance.
- Practice leaders had oversight of MHRA alerts, incidents, and complaints, and reviews were undertaken to assess subsequent changes to ensure they had improved the service as well as reduced risk.

Are services well-led?

Good

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

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- We spoke with the chair of the PPG who informed us that the group was treated respectfully and was listened to by the practice. The practice was open with them when things had gone wrong and discussed complaints with them when this was appropriate. The PPG helped to influence issues that impacted upon patients, for example the telephone monitoring system and worked with the leadership team to implement and deliver changes.
- The PPG had undertaken patient surveys from 2013 on an annual basis. Results were illustrated and areas for improvement identified. This was reviewed with the leadership team and PPG at meetings.
- The results of the NHS Friends and Family Test were consistently positive and we reviewed returns over the preceding three months which showed that the majority of patients would be 'extremely likely' or 'likely' to recommend the service to others.
- A newsletter was available to for patients and the practice had taken full page articles in a local community magazine to engage with the local area on topical subjects and explain any changes which could patients so they were aware of the benefits and how it would affect them.

Continuous improvement and innovation

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

- The practice had initiated a quality management system to allow for departmental self-audits which were then cross-audited by another department lead. This had been promoted by the CCG as an innovative step to managing risk.
- The implementation of the 'Acute Illness Team' had entailed a significant amount of planning and promotion to ensure patients were familiar with the benefits and the reception team were able to allocate appointments safely and effectively. The practice were reviewing the outcomes of the team to ensure there were benefits to the patients and time would tell as to the perception patients had about access.