Audley Health Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 12 January 2015 as part of our new comprehensive inspection programme.

The overall rating for this practice is outstanding. We found the practice to be outstanding in the effective, responsive and well led domains. We found the practice to be good in the safe and caring domains. We found the practice provided outstanding care to people with long term conditions.

The performance that led to the ratings of outstanding in effective, responsive and well-led services apply to everyone using the practice. The achievement of these ratings meant that the practice also provided outstanding services to all population groups including older people, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- Patients felt that they were treated with compassion, dignity and respect. The results of local and national patient opinion surveys were highly positive.
- Practice staff were keen to share learning and provided numerous opportunities for medical students to develop under their guidance.
- Patients told us the practice had a good range of appointments available that suited their needs and it was easy to make an appointment.

We saw several areas of outstanding practice including:

- The quality and range of care provided was high. The practice offered a comprehensive range of services in house. Patients who required diagnostic tests for skin conditions, assessment of cardiovascular (heart and blood vessel) function received them at the practice. This resulted in lower referral rates and waiting times

Summary of findings

for patients. The practice had lower than local and national rates for emergency admissions and contact with accident and emergency departments and out-of-hours services. Patients told us that the practice offered the services and continuity they wanted and this was reflected in higher than average patient survey results.

- The practice was inclusive for all. The practice cared for a number of patients who had previously displayed challenging behaviour and had developed positive relationships with them to address their behaviour. Also staff and students who had experienced difficulty were given high levels of support and had achieved high outcomes. The high levels of engagement and support provided by staff was evident throughout our inspection.
- Leadership at the practice was reflective, strong and decisive. Although already achieving high outcomes in a number of areas, the practice team wished to improve their services and the experience of patients.

However, there were also an area of practice where the provider needs to make improvements.

The provider should:

Ensure that the system for monitoring and providing medicines for patients who receive anti-coagulation therapy and are housebound is robust and understood by all staff involved in their care.

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. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up-to-date with both National Institute for Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence that confirmed that these guidelines were influencing and improving clinical practice and improving outcomes for patients at the practice. We saw data that showed that the practice was performing highly when compared to neighbouring practices in the clinical commissioning group (CCG). Emergency unplanned admissions in all groups of patients were lower than the local average. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. Patients were able to access a wide range of services at the practice, which enabled patients to be treated nearer to their home. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group

Summary of findings

(PPG). The practice had reviewed the needs of their local population and engaged with the NHS Area Team (AT) and clinical commissioning group (CCG) to secure service improvements where these had been identified.

Patients reported good access to the practice and a named GP or GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for providing well-led services. The practice had a clear vision which had quality and safety as its top priority. The practice had planned its services based on the needs of patients. We saw that the practice regularly reviewed outcomes for patients and implemented plans to improve them further. High standards of care were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. We found that there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice regularly sought feedback from patients, which included using new technology, and had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding in providing effective, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the population group of people with long-term conditions. Patients in this group had individualised plans which detailed the action to take if the symptoms of their condition started to worsen. An example was patients who were diagnosed with asthma, local CCG data that patients with a diagnosis of asthma were 50% less likely to attend hospital in an emergency than the local average. The practice had implemented the British Lung Foundation (BLF) principles of asthma care and had provided information to patients in the form of an individualised asthma plan. The plan gave details on the action to take if the symptoms of asthma worsened. Emergency admission rates for other long term conditions for example chronic obstructive pulmonary disease (COPD) was also lower than the local average. The practice had higher than average for the number of patients who had their condition reviewed regularly. The range of services provided at the practice minimised the need for patients with a long-term condition to travel to hospital for treatment and changes to medication, including tests for lung function, blood monitoring, the initiation and monitoring of medication in this patient group.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding in providing effective, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For

Summary of findings

example, children and young people who had a high number of A&E attendances. The practice had been involved in developing a protocol with the CCG to promote best practice treatment for children who experienced croup (an infection of the upper airway). Data from the CCG showed that children registered at the practice who experienced a lower respiratory tract infection (chest infection) were 33% less likely to be admitted to hospital in an emergency than the local average. Immunisation rates were high for all standard childhood immunisations.

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding in providing effective, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

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 as well as a full range of health promotion and screening which reflected the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding in providing effective, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and 94% of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities and recognised their individual needs. For example, they used the same members of practice staff and visited the patient at home if that avoided distress to the patient.

Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. 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 and out-of-hours.

People experiencing poor mental health (including people with dementia)

Outstanding 

The practice is rated as outstanding in providing effective, responsive and well-led services. The high standards which led to these ratings apply to everyone using the practice including this population group.

All people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups and in house wellbeing services were provided on site. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

On the day of our inspection we reviewed 38 comment cards, which had been completed in a two week period before the inspection date.

All of the comments we received were positive about the experience of being a patient registered at the practice. There was a recurrent theme of patients saying that they were treated with support and care. There were 14 cards that contained positive comments about the availability of appointments.

We also spoke with nine patients and their views aligned with the comments in the cards we received. Patients gave us positive examples of treatment they received and support offered by practice staff. All said they were treated with dignity, respect and kindness by staff.

Results from the most recent GP national patient survey in January 2015 stated that 92% of patients rated their overall experience of the practice as at least good. Also 95% of patients would recommend this GP practice to someone new to the area. The practice had one outcome in line with the local and national average and had higher outcomes in all other areas of the survey.

We also reviewed results from the practice's own patient survey. This survey involved 450 patients. The results of this survey were positive surrounding the care and treatment provided at the practice. For example 93% of patients surveyed would recommend the practice to someone needing similar care or treatment. We saw that 68% of patients surveyed rated the ability to speak to a receptionist without being overheard as at least good.

Areas for improvement

Action the service SHOULD take to improve

Ensure that the system for monitoring and providing medicines for patients who receive anti-coagulation therapy and are housebound is robust and understood by all staff involved in their care.

Outstanding practice

The quality and range of care provided was high. The practice offered a comprehensive range of services in house. Patients who required diagnostic tests for skin conditions, assessment of cardiovascular (heart and blood vessel) function received them at the practice. This resulted in lower referral rates and waiting times for patients. The practice had lower than local and national rates for emergency admissions and contact with accident and emergency departments and out-of-hours services. Patients told us that the practice offered the services and continuity they wanted and this was reflected in higher than average patient survey results.

The practice was inclusive for all. The practice cared for a number of patients who had previously displayed challenging behaviour and had developed positive and engaging relationships with them to address their behaviour. Also staff and students who had experienced difficulty were given high levels of support and had achieved high outcomes. The high levels of engagement and support provided by staff was evident throughout our inspection.

Leadership at the practice was reflective, strong and decisive. Although already achieving high outcomes in a number of areas, the practice team wished to improve their services and the experience of patients.

Audley Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. It included a GP, a practice nurse and an expert-by-experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Audley Health Centre

Audley Medical Centre is situated in the village of Audley, within the borough of Newcastle under Lyme, North Staffordshire. Audley is a former coal mining village and has a higher than local and national average prevalence of people with chronic obstructive pulmonary disease (lung disease).

The practice is situated within a large modern building which also houses other health professionals such as district nurses and podiatrists.

Patients of all ages are registered at the practice. There are currently just under 10,000 patients being cared for.

There are a total of six GPs (two male and four female) working at the practice. The practice has a nursing team compromising of seven female staff. This includes a matron, nurse practitioner, two practice nurses, one trainee practice nurse and two healthcare assistants. The administrative team is led by a practice manager and assistant practice manager, and contains 12 reception and clerical staff.

The practice is a locally designated Advanced Training Practice for a range of students including medical students, nurses and qualified doctors who are training to become GPs. An Advanced Training Practice is selected by the Health Education West Midlands as having the expertise and experience to meet the needs of trainee doctors who need additional support and mentoring during their training. These are usually long standing training practices with a dedicated approach to education. Student nurses are also placed at the practice to undertake training in primary care.

The practice offers a range of enhanced services in house which includes minor surgery, 24 or 48 hour blood pressure and heart rhythm monitoring, spirometry (the assessment of lung function), the initiation and adjustment of insulin for patients with diabetes and full monitoring and instant adjustment of anti-coagulation therapy medication. Anti-coagulation medication is given to help reduce the risk of forming blood clots associated with certain medical conditions or after surgery.

Patients who had previously displayed unacceptable behaviour to healthcare workers at practices within the clinical commissioning group (CCG) area are cared for at the practice. This is also an enhanced service and aims to develop positive and engaging relationships with patients in this group, of which some have multifactor influences that may make them vulnerable.

The practice holds a Personal Medical Services contract with NHS England.

The practice does not provide out-of-hours services to the patients registered there. These services are provided by Staffordshire Doctors Urgent Care Limited.

Detailed findings

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 January 2015. During our visit we spoke with a range of staff including four GPs, two practice nurses, the practice manager and five members of reception and clerical staff. We also spoke with others who had experience of dealing with the practice including staff from a local residential home, a community nurse and an allied health professional. We spoke with nine patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate that it used a range of information to identify risk and improve patient safety. The staff we spoke with were clear about their responsibilities for raising concerns. We saw an example of an occasion when a patient received a vaccine in circumstances that might have led to an increased risk of side effects. This occurrence was recorded as a significant event which led to an investigation, discussion and issuing of guidance to clinical staff about patients that required a clinical review before they received vaccines. A GP explained the way in which alerts from outside partners, serious events and complaints from patients were managed. The practice had been recording significant events for over 10 years. The records we saw showed the practice had shown evidence of a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw that there were computerised records of events that had occurred over the last 10 years. Significant events were discussed on a two weekly basis as an agenda item at the management meeting. When required the practice undertook a more depth analysis of significant events at a clinical meeting. We reviewed all events recorded in the previous year. These events were investigated, discussed and action plans were set. We saw that significant events were revisited after three months to minimise further risk. There was evidence that the practice had learned following such events and that findings were shared with staff.

Staff including GPs, practice nurses and receptionists demonstrated the system for reporting incidents and near misses. A GP showed us their system for monitoring and managing incidents. The GP told us that incidents tended to be raised by senior leads within the practice. This was thought to be due to more junior staff approaching a senior figure directly with concerns. The practice had issued guidance to staff of all levels to encourage them to also record the incident as well as raising it face to face.

We tracked the previous year's recorded significant events. We saw that each event had been investigated and discussed. Actions taken were appropriate and each incident was revisited to reassess the risk. There had been five incidents relating to patients taking oral anti-coagulation medication. Anti-coagulation medication is given to help reduce the risk of forming blood clots associated with certain medical conditions or after surgery. Four of these events related to patients that were housebound. This meant they were unable to attend the practice for patient side testing and medication dosing. Patient side testing allowed the clinical member of staff to take a blood sample and analyse the result instantly at the practice. Most of these incidents related to patients who had been temporarily unwell or recently discharged from hospital. There had been confusion from patients, carers and community nurses about who was responsible for the management of medication for this group of patients. A GP showed us the action that had been taken after each individual incident. These actions were reasonable, however the results showed a trend of incidents in a small number of housebound patients. We have asked the practice to look at their management of patients who take anti-coagulation medication and are housebound.

National patient safety alerts were disseminated by email and at the clinical meetings to staff. Staff we spoke with told us that they had received information about alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received training to an appropriate level in safeguarding children and vulnerable adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in both working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

The practice had two GPs identified as leads for safeguarding vulnerable adults and children. All GPs and practice nurses had received training to an appropriate level in safeguarding children. The GP lead for safeguarding had received additional training in safeguarding and had experience of working at a senior level within the clinical commissioning group (CCG). All other staff had completed

safeguarding training to an appropriate level for their role. All of the staff we spoke with were aware of who the nominated safeguarding leads were and how to raise a safeguarding concern.

Safeguarding concerns had recently become a standing item on the clinical meeting agenda.

The practice had a chaperone policy. A chaperone is an impartial, trained observer who is usually a health professional to safeguard the interaction between both patient and clinician during consultations. The policy and signage stating the availability of chaperones was visible on the waiting room notice board, consulting rooms and detailed on the practice website. All nursing staff had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, all receptionists had also undertaken training and understood their responsibilities. This included where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures and described the action to take in the event of a potential failure. The practice staff followed the policy. We saw records to confirm staff members undertook daily checks of the medicines.

Processes were in place to check medicines were within their expiry date and suitable for use. All of the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Three out of four members of nursing staff were qualified as independent prescribers. We spoke with one of these nurses who confirmed that she received regular supervision and support in her prescribing role. The nurse also confirmed that she had received further training to enable her to prescribe in clinical situations. The nurse who was not qualified as an independent prescriber administered vaccines using directions that had been produced in line with legal requirements and national guidance.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept secure at all times and were handled in accordance with national guidance. All blank prescription forms were kept locked and were tracked to ensure they could be accounted for.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We reviewed cleaning schedules and records detailing the frequency and areas of cleaning undertaken. These schedules were detailed on an individual room basis and took into account the purpose of how each room was used. The practice manager showed us minutes of monthly audits undertaken which highlighted any areas that needed improvement in relation to the cleaning schedules. We saw that practice staff fed back daily to the cleaning staff in a communication book. All of the patients we spoke with said they always found the practice to be clean and tidy and had no concerns about cleanliness or infection control.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits in the last year and that any improvements identified for action were completed on time.

The infection control lead had produced a policy on infection control for the practice. We reviewed this document and found it to be comprehensive and detailed the actions required to minimise the risk of infection. The policy had a strong evidence base and was referenced to published best practice and legislative guidelines.

The practice had identified an isolation room and developed a policy on the action to take in the event of a patient presenting with symptoms of an infectious illness. This policy had recently been implemented and took account of best practise guidance.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

Good

Are services safe?

There was a good supply of personal protective equipment in the form of disposable gloves, aprons, eye protection and covers in clinical areas for staff to use to minimise the risk of the spread of infection.

The practice had a policy for the management, testing and investigation of legionella (a germ in the environment which can contaminate water systems in buildings). We saw records that confirmed the contractor employed by the practice to carry out regular checks in line with this policy had carried out regular water testing checks as required.

Equipment

Staff we spoke with told us that they had suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the date of last test. We saw evidence of calibration of clinical equipment. One example was a manual blood pressure sphygmomanometer (a piece of equipment used to take a blood pressure reading).

Staffing and recruitment

There had been little change in staff turnover at the practice during the last few years. The practice had a recruitment policy which detailed the required checks required before a new staff member was employed. These included checks on identity, employment history, professional qualifications and criminal records checks through the Disclosure and Barring Service (DBS). We tracked the records of the two members of staff most recently employed. The records showed that the policy had been followed on both occasions.

The practice manager told us the practice management team had made the decision in the previous year to perform DBS checks on all staff. We found that all staff at the practice had current DBS checks in place at a level relevant to their role.

We looked at the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. Peak times of demand had been identified and staff rotas reflected these. For example all GPs offered appointments on a Wednesday which required a higher number of reception staff to deal with the higher volume of patients. All administrative staff had received training and recent experience to enable them to answer telephone calls from patients and use the practice computer system to book appointments. The practice manager commented that this helped to reallocate staff in the event of high demand or staff illness.

Staff told us there were usually enough staff to maintain the smooth running of the practice and always enough staff on duty to keep patients safe. We looked at records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Identified risks were included in a risk assessment document. Each risk was assessed and rated with mitigating actions recorded to reduce and manage risk. An example of managing risk was installing backup clinical software on 10 computers in the practice. These could be used as an alternative in the event of a failure with the main computer system.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support and treatment of anaphylaxis (allergic reaction). Emergency equipment was available at a secure central point on a portable trolley. Equipment included oxygen therapy and a nebuliser (to assist someone with difficulty in breathing) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm). There were also pulse oximeters (to measure the level of oxygen in a patient's bloodstream). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked on a weekly basis.

We spoke with a patient who told us that when they booked in for an appointment at the reception desk, they presented with symptoms of chest pain that could have indicated a serious medical problem. The receptionist

Good

Are services safe?

immediately summoned a GP who saw the patient straight away. All of the staff we spoke with knew how to identify an emergency and could tell us the actions they would take in response to this.

Emergency medicines were available in a lockable drawer on the emergency equipment trolley and an individual supply was available to each GP. These medicines were comprehensive and could be used to treat a wide range of medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a person suffers a seizure/fit) and hypoglycaemia (a very low blood sugar reading). Processes were also in place to check on a weekly basis whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a service continuity plan in plan to deal with unplanned events that may occur and would hinder operation of the practice. Each risk had been rated and mitigating actions recorded to reduce and manage the risk. The plan included details of alternative accommodation to operate the practice from in the event of a major issue with the existing premises. The document also contained details of who to contact in the event of specific issues, for example a computer system failure.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline their approaches to treatment. All were knowledgeable on best practice guidelines and accessed guidelines from the National Institute for Care Excellence (NICE), professional bodies and local commissioners. One of the GPs was the primary care director on the local clinical commissioning group (CCG) board. Another GP was a non-executive director. We saw that clinical staff met on a two weekly basis. New guidelines were discussed with the implications for patients and performance considered and actions agreed.

The practice provided an enhanced service which provided the 3% of patients most at risk of unplanned admissions to hospital with an individualised care plan. An enhanced service is a scheme either local or national set up to address specific health needs and priorities. The directed enhanced service provided 2% of at risk patients with care plans. The practice had signed up to a local enhanced service to provide a further 1% of patients with this service. A GP told us that they had identified patients for the enhanced service by using clinical knowledge, relationships with patients and a computerised risk tool. We reviewed a selection of care plans and saw that they contained up to date information, were personalised and they demonstrated the needs and wishes of patients had been recorded. CCG data showed that the practice had lower than average emergency admissions in all areas.

Data from the CCG showed that patients at this practice who experienced poor mental health (including those with dementia) had higher than local average outcomes in all areas. For example, all 62 patients on the mental health register had a comprehensive care plan and had received a physical health check in the previous 12 months. The CCG average was 75%. Another example was that the number of emergency admissions for patients with dementia was half the CCG average.

The practice had identified 101 patients who were at risk of developing dementia. These patients had been assessed and referred to a dementia clinic for diagnosis where appropriate. As a result 13 additional patients had been diagnosed with dementia. These patients had been included in the register of patients at risk of unplanned admission to hospital increasing the number of patients on the register by 18%. This meant that these patients had received personalised care plans which helped them to plan their care in the future and receive the appropriate support.

The GPs told us how they led in specialist clinical areas such as diabetes, minor surgery and asthma. Practice nurses supported this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The minutes of practice meetings confirmed learning was shared between clinicians and best guidance was discussed which led to change in practise.

We looked at performance data from the CCG containing 50 outcomes spanning a wide range of patient groups and conditions. In most of these outcomes the practice had higher performance than the local average. Sixteen of these were highlighted as being in the range of significantly better than average.

The practice had significantly lower than the local average referral to outpatient care. A GP told us they felt this was due to the range of extended services they held in house. These included a wide range of minor surgical techniques including vasectomy, toe nail surgery and removal of lumps.

Patients with a long term conditions, for example, chronic obstructive pulmonary disease (COPD) had received clear guidance on the actions to take in the deterioration of their breathing. COPD is a term for a number of diseases which affect the function of a person's breathing. Patients in this group had individualised management plans which included information about symptoms and vital signs that would be normal for them. This information would help a clinician who was not familiar with the patient to understand their normal condition and if this had changed due to illness. The plans were reviewed at three or six monthly intervals. A number of patients with COPD (39%) also had access to a rescue pack at home. Rescue packs contained antibiotics (to treat a bacterial infection) and steroids (to reduce inflammation). When a patient experienced the symptoms of a chest infection they could immediately start treatment. A GP told us that this helped patients to have rapid access to treatment at all times.

We reviewed information from the CCG that showed the practice that patients with COPD had a lower than average emergency admission to hospital rates. The practice admission rate was 7.9 per 1,000 patients compared with a

CCG average of 11.1. These results showed that patients with COPD were less likely to be admitted to hospital in an emergency than other local practices. This performance was despite the practice recording a higher than average number of patients with COPD than other local practices (practice ratio 2.2% vs a CCG average of 1.9%).

Patients diagnosed with asthma also had improved outcomes than the local average. We saw that 80% of patients diagnosed with asthma who had received a health check had personalised action plans. Each plan gave instructions on the actions to take if the symptoms of asthma became suddenly worse. The health check also focussed on the technique of how to take preventing and relieving medication. A GP told us they believed the practice was supporting patients with asthma to self-manage and recognise when their asthma deteriorated. The CCG Quality and Outcomes Framework (QOF) data supported this, as patients in that group were nearly 50% less likely to attend hospital in an emergency than the local average.

Children with lower respiratory tract infections (chest infections) were 33% less likely to be admitted to hospital from this practice in an emergency than the local average. A GP told us that they felt this was due to the robust way in which children were assessed and managed. The GP also told us the practice team had taken an active role in developing a CCG protocol for treating children with croup (an infection which can cause inflammation in the upper airway) with oral steroid medication to help to reduce the severity of the symptoms experienced.

All of the GPs we spoke with used national standards for referral of patients with suspected cancers to a specialist and patients were seen within two weeks.

The practice had a weekly session held by the local Improving Access to Psychological Therapies (IAPT) practitioner. A GP told us having the service in house had helped to develop professional relationships and allowed them to adjust treatment and patients individual care plans as required. The practice GPs had directly referred 242 patients to this service in the last 12 months. The GP also commented many more patients had been provided the information to self-refer to therapy, although this was not coded so difficult to give an exact amount.

Minor surgery was provided at the practice and was audited on a yearly basis to look at the effectiveness of the intervention also the instance of complications that can occur such as infection or excessive bleeding. We saw that the minor surgery audit revealed low complication rates. A GP who provided minor surgery told us that if they performed any surgery on the toenails, they performed an ultrasound Doppler test on at risk patients to ensure the blood supply to the foot was adequate. This was done to reduce the likelihood of poor healing to the area caused by a lack of a rich blood supply.

The practice offered an enhanced in house range of services which included the initiation and adjustment of insulin for patients with diabetes and full monitoring and instant adjustment of anti-coagulation therapy medication. Anti-coagulation medication is given to help reduce the risk of forming blood clots associated with certain medical conditions or after surgery.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making

Management, monitoring and improving outcomes for people

The practice showed us seven clinical audits that had been undertaken in the last 18 months. Six of these were completed audits where the practice was able to demonstrate a positive change since the initial audit. For example, an audit had identified a higher level of referral of patients to skin specialists than the local average. The audit examined the reasons for and outcomes for each patient referral. Learning from the audit was shared amongst clinicians. Two GPs undertook additional training to provide an in house assessment of skin conditions using a dermatoscope (an instrument to allow the clinician to view skin cells in greater detail). This had resulted in GPs becoming more confident in the diagnosis of skin conditions which led to lower referral rates. Importantly, the number of diagnoses of skin cancers in patients had remained at the same level. This indicated that serious conditions were not being overlooked. We also saw an audit which confirmed that the GP who undertook minor surgical procedures was doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from Quality and Outcomes

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Framework (QOF). For example we saw an audit of the referral of patients with suspected cancers seen by a specialist within two weeks. This audit looked at the attendance of patients before referral and examined if referral could have been made sooner. Following the audit GPs had altered their referral practise which led to an increase in the number of patients referred under the two week referral pathway. The two week referral pathway is a national target designed to give patients with suspected cancer a consultation with a specialist within two weeks of referral. This meant an increased number of patients from the practice were being diagnosed with cancer through the two week referral pathway.

We also saw records that showed that GPs had looked reflectively at groups of patients who had experienced a medical illness that may have been preventable. An example of this was reviewing records of all patients who had experienced a new myocardial infarction (heart attack). These patients had been reviewed and their history presented at clinical meetings. A GP told us this helped staff to reflect if any action could have been taken to minimise the event occurring. Other conditions clinicians looked at included emergency admissions for patients with asthma, newly diagnosed diabetes and patients who had experienced a stroke.

The practice had introduced a range of in house procedures including the use of spirometry (assessment of lung function) and 24 hour blood pressure and electrocardiogram (ECG) monitoring. An ECG records a patient's heart rate and rhythm. A GP told us this had improved the speed in which diagnosis could be made as hospital waiting times were significantly longer than at the practice. The GP also commented that it brought the procedures closer to home for patients which meant they did not have to travel as far to receive treatment.

A named GP was responsible for ensuring that patients on registers had received the reviews they required as part of their illness or condition. These groups of patients included those with long term conditions, for example patients with diabetes, heart failure or asthma. The CCG data we reviewed confirmed that the practice had performed at a significantly higher level in the care of patients with diabetes. Of the five indicators related to ongoing screening of patients with diabetes, we found that the practice had improved outcomes. An example was 93% of patients had a recently recorded blood pressure within accepted limits. This had improved on the previous two years and was 23% higher than the local average and also 14% higher than the national average. This meant that this group of patients may be at a lower risk of developing the medical complications associated with high blood pressure in diabetes.

All GPs participated in peer review of referrals. All new diagnoses of patients with cancer and referrals to hospital doctors were discussed at clinical meetings and alternatives explored. A GP commented that this helped them to explore alternatives that may have been more suitable for each patient. Also to ensure appropriate referrals were timely. The practice participated in a local bench marking scheme within the CCG. This compared performance with other local practices and helped to share best practice between the members. This benchmarking data showed that most of the practice outcomes were higher than the local average.

Effective staffing

The practice had an experienced team of staff that included medical, nursing, managerial and administrative staff. We saw staff turnover had been very low. The existing GP partnership had remained unchanged for the previous eight years. A strong diverse skill mix was noted amongst the doctors with three having additional diplomas in sexual and reproductive health, one with a diploma in palliative medicine (the overall care of patients with advancing conditions). Five GPs had certificates in women's health and two held certificates in medical education. The GPs also held further qualifications in other areas of care and medicine. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice held long well established links with local medical schools and had provided training for student doctors and doctors continuing in their education. Medical students in years three and five of training to become doctors were placed at the practice. Doctors in the second foundation year of post qualifying and doctors in years two and three of specialist training to become GPs were also supported in further education. The practice also provided

high level support to trainee doctors who had experienced difficulty during training. We spoke with a trainee doctor who had been placed at the practice under this scheme. They were highly complementary about the high level support and mentoring they had received from all staff at the practice. A supportive and positive culture within staff was evident throughout our inspection. Student nurses and trainee practice nurses also undertook placements at the practice to develop their skills.

All staff undertook annual appraisals which identified learning needs and the practice was proactive in providing training or funding for education in the areas identified. All of the nursing staff at the practice had been funded to undertake further education in triage and physical assessment, independent prescribing and a degree if appropriate.

Nursing staff at the practice had defined duties and were able to demonstrate they were trained to fulfil these duties. For example undertaking of spirometry and family planning. Those with extended roles for example triage had extended training in physical assessment. The lead nurse for asthma had completed a diploma in asthma care. Two health care assistants were employed at the practice. Both had undertaken formal nationally recognised training in health care and in extended skills such as taking blood samples.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a member of staff who held responsibility for passing on and acting on any issues that arose from communications with other care providers. All of the GPs and nurses had a role to action and follow up any issues that arose. The lead administrator also had access to view whether results had been viewed by a GP. The records we viewed showed there had been no instances in the last year of any results or discharge summaries that were not followed up properly. We saw numerous examples of when practice staff had actively followed up results, tests and other referrals to ensure their patients received tests and treatment in a timely manner.

We spoke with two district nurses and one allied health professional who were based at the practice but not employed by them. All of these healthcare professionals spoke very positively about the professional working relationship and interactions between practice staff and themselves. One commented that the GPs were highly accessible and they felt that they could go directly to the GPs with any concerns about a patient.

The practice held multidisciplinary team meetings every six weeks to discuss the needs of patients who had complex needs. An example was for patients who were approaching the end of their life. Meetings were attended by all GPs, nursing staff, district nurses, palliative care nurses and the practice manager. The meetings were documented and decisions about care planning were placed in a shared care record kept in the patient's home. Staff commented that this system allowed information sharing and ensured that staff visiting patients had access to records from all the healthcare partners involved. The practice team also held meetings every six weeks with the Integrated Local Care Team (ILCT) to discuss the needs of patients with complex health and social needs. The ILCT aimed to join up care between medical and social care partners to help ensure a patient's overall care needs were being met.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice made all referrals possible last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

We were shown the system for recording special notes that were entered into the shared system. An example of this was information regarding patients approaching end of life. Clinical information and wishes were recorded and uploaded to the system. This meant if the patient needed assistance when the practice was closed the out-of-hours GP provider would have access to the information.

For emergency patients, there was a practice policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this

communication with A&E. The practice also provided the electronic Summary Care Record. Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information.

The practice had systems in place to provide staff with the information they needed. An electronic patient record called Vision was used by all staff to coordinate, document and manage patients care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

All of the staff we spoke with were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke with had received training and clearly understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. The care plans were reviewed at least annually (or more frequently if changes in clinical circumstances dictated it). We reviewed a sample of care plans and saw they contained information about a patient's capacity to give consent. When a patient had a condition that could mean their capacity may be impaired in the future, their wishes had been expressed in the form of an advanced directive. An advanced directive expresses the treatment or care a patient wishes to receive or not receive in the future. This helped to ensure a patient's wishes were upheld in the event they could not communicate. There was also a section which enabled a patient to give consent for a relative to communicate with GPs on the patient's behalf.

The latest QOF data we reviewed showed the practice had reviewed 89% of patients with dementia in the previous year. This was 9% higher than the local average and 7% higher than the national average.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. A GP told us that consent for minor surgery was always documented in patient records and if not recorded the surgery would not take place.

Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients registering with the practice a health check with a health care assistant. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 25% of patients in this age group took up the offer of the health check. This performance was higher than the national average of 15.2%. A GP showed us how patients who had risk factors for diseases identified at the health check were followed-up and scheduled for further investigations.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 94% had received a check up in the last 12 months.

The practice provided a smoking cessation clinic to assist patients who wished to stop smoking. QOF data showed

Outstanding ☆

Are services effective?

(for example, treatment is effective)

93% of patients who were recorded as smokers, had received an offer of support and treatment within the last two years. This result was 14% higher than the CCG average and 8% higher than the national average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was in line with, or above average for the CCG. There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 450 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires undertaken by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, the most recent data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also comparable or above average for its satisfaction scores on consultations with GPs. There were 88% of practice respondents who said the GP was good at listening to them and 92% said the GP gave them enough time. Satisfaction scores on consultations with nurses were well above local and national averages, with 90% of practice respondents recording that the nurse was good at listening to them and 97% saying the nurse gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 38 completed cards and all were highly positive about the service experienced. There were no neutral or negative comments. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with nine patients on the day of our inspection. All told us they were highly satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Washable privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatment in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

The practice had a confidentiality booth which allowed patients to discuss sensitive issues in private. Posters were displayed advertising this facility and most of the patients we spoke with knew of its purpose.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 86% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were above the clinical commissioning group (CCG) and national average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients that this service was available.

Care planning and involvement in decisions about care and treatment

We reviewed comment cards and spoke with patients on the day of our inspection. Three of the patients we spoke with told us that they had received a high level of support from staff at the practice. They also spoke of their experiences of being referred to support services to help them manage their care and treatment. This included bereavement care and weight management. All were highly positive about the support they had received. The comment cards we received were also aligned with this.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

A GP told us that if families had experienced a bereavement their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Comment cards we received were also consistent with this information.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and clinical commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Two of the GPs at the practice held positions on the board of the local CCG. The practice had taken numerous locally available opportunities to implement service improvements and manage delivery challenges to its population. These included securing funding from the CCG to offer extended opening hours on a Saturday in the winter period to assist in relieving the pressure on local hospital accident and emergency services. The practice also provided numerous in house services and tests that would normally be undertaken in hospital. For example the undertaking of 24 hour ECG monitoring in house allowed patients to attend the practice to have the device fitted and removed over a two day period. If this service was not offered at the practice, patients would need to attend the local hospital twice in two days. A GP told us this service meant patients could have the procedure closer to home and this was particularly helpful for older patients and those of working age. The practice also provided other in house procedures including minor surgery, spirometry, blood tests and dermoscopy.

The practice had also implemented suggestions for improvement and made changes to the way it delivered services in responsive to feedback from the patient participation group (PPG). An example was the practice changing the size and colour of the letters on the television screen that alerted patients to proceed to their appointment. Members of the PPG told us this was to assist patients with a visual impairment.

We saw that the practice staff adapted services to fit around patients where possible. We saw an example of when a minor surgery session was moved from a Thursday morning to another day and time to suit a patient who worked on a Thursday.

Tackling inequity and promoting equality

The practice held a contract to provide GP services to patients who had previously displayed unacceptable behaviour to healthcare workers. This was an enhanced service and included patients that were previously registered at other local practices. The scheme included 19 patients, all of whom had been excluded from other local practices, due to displaying behaviour to healthcare workers that was unacceptable and had involved the police. We saw records that included a contract of understanding between the patient and practice staff. This document displayed the behaviours each party expected from each other. The practice manager told us about the development of positive relationships with this group of patients. We saw records which showed there had been no further incidents of poor behaviour involving any of the patients. The practice manager also told us that a number of patients had opted to stay registered at the practice beyond the period of exclusion from their usual GP practice. A number of these patients had underlying issues that may make them vulnerable. A GP told us they would rather engage with these patients to assist with addressing their underlying issues then send them elsewhere.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and promoted this in their work.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had access to telephone translation services for patients whose first language was not English.

Access to the service

Appointments were available from 8am to 6:30pm on weekdays. During these times the practice was open, staffed and all telephone calls answered by practice staff. The practice also offered evening appointments on Monday and Tuesday until 8pm. As part of a winter pressures incentive aimed at reducing pressure on local hospital accident and emergency services, the practice was

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

open on a Saturday morning from 8:30am to 12:30pm until 14 February 2015. Patients were able to book appointments in person, by telephone or online. Telephone consultations with a GP were also available.

The practice varied the amount of appointments available depending on demand. Patients were able to book routine appointments up to two weeks in advance with a preferred GP. Extra appointments were also released on a daily basis. Patients with urgent concerns could book an appointment on the same day. If patients had urgent concerns and no appointment was available they would receive a call back from the nurse practitioner (a registered nurse with enhanced assessment and treatment skills) and arrangements made as appropriate. All of the patients we spoke with on the day of inspection confirmed that they had been able to make an appointment with their preferred GP. This aligned with the comment cards with 14 individual positive references to the availability of appointments. One comment card we received stated that a patient had been able to get two same day appointments promptly for their children who were both unwell.

The data we reviewed from the National Patient Survey showed the practice had performed above the local and national averages in patient satisfaction with appointments. For example 85% of patients rated the overall experience of making an appointment as at least good (CCG average 77%, national average 74%).

We looked at the latest available data from the Quality and Outcomes Framework (QOF). The practice had lower than average rates of patients attending other healthcare partners to access care. This included GP out-of-hours services and accident and emergency departments. In the three indicators related to accessing these areas, the practice was reported to be in the significantly better than average category in all three.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

A carer of a patient who had learning difficulties told us about the treatment their relative received. The practice provided home visits using the same GPs as the patient became distressed if they needed to go in person to the practice. The relative told us that GPs would always visit without question if this was requested. On the occasion a further test was required, a practice nurse visited the patient at home and performed the test which had helped to avoid distress to the patient.

Listening and learning from concerns and complaints

The practice had a 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. The practice website and booklet contained a section on how to make a complaint. There were also notices in the waiting room explaining the action to take in the event of a complaint. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 12 complaints received in the last year and found that all had been dealt with in a timely way and resolved to satisfaction at a local level with no complaints being referred to the Parliamentary and Health Service Ombudsman (PHSO).

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had written aims that included "To deliver high quality, evidence based medical care and health promotion to the local population". Also "To support our staff to develop and grow".

On the day of our inspection we spoke with a number of patients, staff and allied health professionals who all spoke very positively about how these aims were being upheld and modified to meet the needs of patients.

All of the staff we spoke with were able to explain the essence of the practice aims and values. We saw that staff demonstrated a positive approach to the practice aims and comments from patients we received aligned with this.

The practice offered numerous services that provided patients with the opportunity to be treated closer to home. These services included initiation of titration of insulin for diabetic patients, monitoring and adjustment of blood thinning medication for patients at increased risk of blood clots, minor surgery also identification of 3% of patients at high risk of admission to hospital. The practice was performing highly at both a local and national level in the Quality and Outcomes Framework (QOF) outcomes and showed improvement year on year in most areas. In the 50 QOF outcomes we looked at, the practice was banded at a significant higher level than average in 16 areas.

An example of improving outcomes for patients was the care that the practice provided to patients diagnosed with asthma. At the time of inspection the practice had 717 patients with a diagnosis of asthma. We saw that 80% of patients diagnosed with asthma who had received a health check had personalised action plans. Each plan gave instructions on the actions to take if the symptoms of asthma became suddenly worse. The health check also focussed on the technique of how to take preventing and relieving medication. A GP told us they believed the practice was supporting patients with asthma to self-manage and recognise when their asthma deteriorated. The Quality and Outcomes Framework (QOF) data supported this, as patients in that group were nearly 50% less likely to attend hospital in an emergency than the local average.

Patients told us that the practice met their needs and that they felt well cared for and we saw data to confirm this. In 18 areas that related to patient satisfaction in the GP national patient survey, the practice was comparable in one outcome and exceeded all others on a local and national average level.

The practice had recently employed a community matron with the intention of strengthening performance levels further by providing more patients with individualised care plans and reviews. The initial funding for this post had been provided from the clinical commissioning group (CCG), although the time length of funding was limited. The practice management team had taken the decision to make the post a full time permanent position. The practice manager told us that they had done this to attract a suitable applicant and that they were sure that the position was going to positively further improve patient outcomes.

We saw records and spoke with a student and members of staff that showed that practice staff had supported each other at difficult times. They had encouraged development and supported them to improve their own performance and improved individual confidence levels.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures and all six had been reviewed annually and were up to date.

We saw that leadership at the practice was strong and decisive. Staff had taken ownership of lead roles and could demonstrate they had improved outcomes for patients over time. For example a GP was the lead for ensuring patients had received the physical reviews they required as part of their long term condition. There were also leads for safeguarding, infection control and clinical speciality areas. All of the staff we spoke with were clear about their own roles and responsibilities. They all told us that they felt valued, well supported and knew who to go to in the practice with any concerns.

A GP told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement. An example was assisting the CCG to produce best practice treatment

Are services well-led?

Outstanding ☆

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

guidelines for children with croup (an infection which can cause inflammation in the upper airway). Practice staff had input into the protocol with the intention of reducing emergency admissions for children with croup by providing treatment at an earlier stage in the illness.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at six completed audits all of which demonstrated improvements in outcomes. One example was an audit of patients who had recently been diagnosed with cancer. The audit looked at each patient and examined if the diagnosis could have been made sooner which may have improved the outcome for the patient. The audit had been shared with all staff and included discussion and peer review of each case. As a result learning had been shared between staff.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, for example loss of the computer system. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. In the event of the loss of the main computer operating system, practice staff had identified alternative computers and installed a back-up computer system to allow staff to access patient information and guidelines.

The practice held weekly governance meetings and two weekly management meetings. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the confidentiality policy which was in place to protect patients' dignity and to support staff. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients through in house surveys, comment cards and review of the GP national patient survey. We looked at the results of the annual patient survey and a report on comments from patients from the same survey. Patients had expressed concern about being overheard at reception. The practice had improved signage to advertise the confidentiality booth available and had advertised this in the local community magazine. The practice published information from the survey on noticeboards and on the internet in a 'You said… We will' format.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included 15 members which mainly represented the over 40 age demographic. The PPG was actively attempting to recruit a young person and had recruited more female members to become more representative. The PPG had carried out yearly surveys and met every month with practice staff including the practice manager and a GP. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the PPG website.

Two members of the PPG had been recognised by winning an award as NHS heroes 2014, which was issued by a regional newspaper. This was in recognition of the success of raising the profile of the patient voice. Members of the PPG held positions on the locality patient congress within the CCG. This gave patients an active voice in commissioning local services that were important to them and the community. The PPG had a comprehensive website that was independent of the practice site which contained minutes from meetings and health promotion advice.

The practice had gathered feedback from staff through appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

The staff we spoke with told us that they had been supported to develop skills and knowledge appropriate to

Are services well-led?

Outstanding ☆

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

their role. The nursing staff held a diverse range of additional qualifications and skills which enabled them to play a vital part in managing patients' health needs. An example was some nurses were trained to an extended level asthma care and spirometry and provided physical reviews for patients with asthma. Reviews for patients with asthma and emergency admission data showed an improved outcome for these patients than the national average.

The practice was an Advanced Training Practice and offered numerous training opportunities for medical students and qualified doctors to extend their skills. An Advanced Training Practice is selected by Health Education West Midlands as having the expertise and experience to meet the needs of trainee doctors who need additional support and mentoring during their training. These are usually long standing training practices with a dedicated approach to education.

Formal training had been offered at the practice since 2001. Two of the GPs at the practice held additional higher level qualifications in educational teaching. Both of these GPs had been awarded an "Innovation in Training" award by the Midlands division of the Royal College of General Practitioners (RCGP) in 2013. We spoke with both of these GPs. They gave us numerous examples of the positive support that both they and the practice have provided to students. An example is the practice status to provide high level support to qualified doctors who were training to become GPs. The GPs and practice staff had recently mentored two doctors who were experiencing difficulty in completing their GP training. We spoke with one of these trainee GPs. They told us of the high level of support they had received to achieve their career aspiration to become a GP. The practice had supported a high number of trainees at different stages in their training over the previous 14 years.

Reflection and improvement were recurrent themes we saw and heard whilst carrying out our inspection. The practice GPs met on a weekly basis to discuss any clinical issues, guidelines or serious events. We saw evidence although the practice had high performance levels, staff were keen to improve further. An example of this was analysis of patients who had been diagnosed with new illnesses such as strokes or cancer. Practice staff reviewed themes to establish if the condition could have been identified sooner or minimised the risks of these conditions occurring. Learning was regularly shared and applied at all staff levels.