

Cleveleys Group Practice

Quality Report

Cleveleys Health Centre
Kelso Avenue
Cleveleys
Lancashire
FY5 3LF

Tel: 01253 853992

Website: cleveleysgrouppractice.co.uk

Date of inspection visit: 3 March 2016

Date of publication: 13/04/2016

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

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	8
What people who use the service say	13
Outstanding practice	13

Detailed findings from this inspection

Our inspection team	14
Background to Cleveleys Group Practice	14
Why we carried out this inspection	14
How we carried out this inspection	14
Detailed findings	16

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cleveleys Group Practice on 3 March 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice employed a qualified nurse as a care co-ordinator who contacted all patients who had been discharged from hospital, providing a home

visit and full assessment if necessary. We were told that this model of care was to be adopted by the Clinical Commissioning Group (CCG) for other practices.

- Feedback from patients about their care was consistently and strongly positive. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example, the practice met with other practices in the neighbourhood for monthly meetings that included representatives from community services, the police, ambulance services, social services and health and wellbeing workers.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, following a patient complaint, the practice

Summary of findings

reduced the number of appointments that patients with more than one long-standing health condition attended. The practice provided additional training to staff and brought health checks together into one appointment to reduce patient visits to the practice. Longer appointments were provided for this.

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had attained the Royal College of General Practitioners (RCGP) accreditation in 2014. (This award is to reward practice teams who have improved their organisational quality of care to best practice recommended levels). The practice had used the learning from this to produce a performance dashboard that, together with feedback from staff meetings, audit, significant events and patient complaints was used to inform a quality improvement plan. This plan was regularly reviewed and updated at practice meetings.
- There was a clear leadership structure and staff felt supported by management.

- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw several areas of outstanding practice including:

- The practice pharmacist had developed a risk-profiling tool to identify patients who were most in need of having their medications reviewed by the practice staff. The pharmacist continued to audit this work to ensure that risks were reduced and we saw evidence of this.
- One of the practice GPs received direct alerts from the police when they had a concern regarding a vulnerable patient. This enabled the GP to arrange an appointment or visit the patient. The practice was the pilot site for this project.
- A charity providing memory screening for patients attended every fortnight and patients were able to self-refer to these clinics as required. The practice also arranged for this charity to attend a flu clinic on a Saturday.
- The practice had purchased a light box to facilitate staff training and hand hygiene. (A light box enables staff to identify poor hand hygiene practices).

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?

The practice is rated as good for providing safe services.

Good



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

Are services effective?

The practice is rated as outstanding for providing effective services.

Outstanding



- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. One of the GPs was working with the local secondary care services to produce a pathway of care for diabetic patients.
- Data showed that the practice was performing highly when compared to practices nationally and in the Clinical Commissioning Group (CCG). Blood measurements for diabetic patients showed that 88% of patients had well controlled blood sugar levels compared with the CCG average of 85% and national average of 81%.
- The practice used innovative and proactive methods to improve patient outcomes and was working with other local providers to share best practice. The practice had appointed a care co-ordinator to reduce hospital admissions for patients. We saw evidence of a reduction in hospital admissions and were told that this model of care was to be adopted by the CCG for other practices. The practice pharmacist had developed a risk-profiling tool to identify patients who were most in need of having their medications reviewed by the practice staff. We saw evidence that this was reducing risk for these patients.

Summary of findings

- A planned programme of clinical audit and re-audit was established. Clinical audits demonstrated quality improvement and were used to develop consistent approaches to clinical care. Six of the nine audits that we reviewed were re-audits to assess progress of care and treatment.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice recruited and trained staff to support the optimum delivery of care for patients.

Are services caring?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for several aspects of care. For example, 92% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Feedback from patients about their care and treatment was consistently and strongly positive. This reflected the results of the GP patient survey published in January 2016.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- External stakeholders, such as the local nursing homes told us that the practice staff responded quickly to any concerns they raised about patients.

Good



Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. The practice attended monthly meetings with other practices and representatives from community services, and other external agencies.
- There were innovative approaches to providing integrated person-centred care. The practice was developing a service for some wound care patients.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a

Outstanding



Summary of findings

consequence of feedback from patients and from the patient participation group. For example, appointments for patients with more than one chronic illness were streamlined to reduce patient visits to the practice.

- Patients could access appointments and services in a way and at a time that suited them. Following a patient survey, the practice offered lunchtime surgeries and early morning appointments as well as Saturday opening.
- Data from the National GP Patient Survey showed that 41% of patients said that they always or almost always got to see or speak to their preferred GP compared to the CCG average of 33% and the national average of 36%. Also 97% of patients said that were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 84% and national average of 85%.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- The GPs provided ward rounds for local nursing homes at least once a month. This enabled the GP to carry out any advance planning for end of life patients with the patient and members of their family and provided continuity of care.

Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this.
- A comprehensive understanding of the performance of the practice was maintained. To enable this, the practice had produced a performance dashboard. This dashboard included many high level areas of practice, both clinical and administrative and was populated with data from external and internal systems available to the practice. The data then informed a practice quality improvement plan along with feedback from staff meetings, patient feedback and practice surveys.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

Outstanding



Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and was regularly consulted.
- The practice had attained the Royal College of General Practitioners (RCGP) accreditation in 2014. (This award is to reward practice teams who have improved their organisational quality of care to best practice recommended levels).
- There was a strong focus on continuous learning and improvement at all levels.
- There was a proactive approach to developing new ways of providing care and treatment. This was clearly evident in the practice's appointment of a care co-ordinator for patients who had had hospital admissions. It was also evidenced by the practice acting as a pilot site for new patient services and supporting staff to develop new care pathways for wound management.

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

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice employed a nurse to co-ordinate care for patients who have had an admission to hospital. On discharge, the nurse either contacted the patient by telephone or by visiting them at home. If appropriate, a full clinical assessment was undertaken, a care plan produced and further referral made to other services if needed.
- The practice acted as a pilot site for a new service that was introduced in 2015. This service offered care for patients at risk of admission to hospital and who would benefit from proactive management.
- A charity providing memory screening for patients attended every fortnight and patients were able to self-refer to these clinics as required. The practice also arranged for this service to attend a flu clinic on a Saturday.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had a robust system to follow up patients who did not collect their repeat prescription or failed to attend their appointment at the practice or hospital.
- The practice worked and communicated well with local nursing homes. GPs provided regular visits and conducted ward rounds with the nursing home staff. Care planning was provided for these patients including end of life planning. Patients' families were involved wherever possible.
- Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.

Outstanding



People with long term conditions

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

- Nursing staff had lead roles in chronic disease management and the practice planned strategically to enable continuity of care for patients.
- The practice achieved 99.5% of available points via QOF in 2014-15. Key achievements for diabetes included 90% of

Outstanding



Summary of findings

patients with diabetes whose blood pressure readings were equal to or below recommended levels. This was 6% above the CCG average and 12% above the national average. The practice had reported 8.9% of diabetic patients as exceptions compared to the CCG average of 14.1% and the national average of 10.8%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had worked to streamline review appointments for patients with more than one long-term condition so that visits to the practice could be reduced.
- The practice pharmacist had developed a risk-profiling tool to identify patients who were most in need of having their medications reviewed by the practice staff. We saw evidence of reducing risk for these patients.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Results from the QOF for 2014-2015 showed that 80% of patients with asthma who were on the practice register had had an asthma review within the previous 12 months compared to the national average of 75%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The cervical screening uptake for women aged 25 to 64 was 80%, which was comparable with the CCG and national averages.

Good



Summary of findings

- Appointments were available outside of school hours and the premises were suitable for children and babies. Children under the age of five were always seen or telephoned on the same day by a healthcare professional and under one year of age by a GP.
- We saw positive examples of joint working with midwives, health visitors and school nurses. The practice ran baby clinics with the health visiting service. The GP, practice nurse and health visitor continued to offer checks to seven to nine month old babies even though funding for this had been removed nationally. This helped provide a continuing relationship with the practice and encouraged further attendance for baby health checks and immunisations. Concerned parents were encouraged to use the clinics as a drop-in service.

Working age people (including those recently retired and students)

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered appointments from Monday to Friday from 7.40am to 6.50pm and on Saturdays from 8am to 1.50pm.
- Telephone appointments were also available for patients who needed advice but were unable to attend the surgery.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. We saw that online appointments were available for all GPs.
- A 24-hour telephone prescription ordering service was available as well as online ordering.

Good



People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. One of the practice

Outstanding



Summary of findings

GPs received direct alerts from the police when they had a concern regarding a vulnerable patient. This enabled the GP to arrange an appointment or visit the patient. The practice was the pilot site for this project.

- The practice attended monthly neighbourhood meetings with other practices, community services and external agencies including members of the community police Early Action team who discussed patients who were at risk.
- The practice informed vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.
- The surgery offered a shared-care service with the local drug and alcohol service.

People experiencing poor mental health (including people with dementia)

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

- 78% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average.
- The practice had recorded an agreed care plan for 91% of patients with a recognised mental health problem compared to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- A mental health counsellor ran weekly clinics in the surgery and staff could refer patients to this service. A recent local initiative enabled patients to self-refer to these when appropriate.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia and all staff had undertaken dementia awareness training.

Good



Summary of findings

- The practice had a register of patients who were subject to a Deprivation of Liberty Safeguards (DoLS) and staff had a good understanding of DoLS.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing above local and national averages. 254 survey forms were distributed and 110 were returned. This represented 1% of the practice's patient list.

- 79% found it easy to get through to this surgery by phone compared to a CCG average of 78% and a national average of 73%.
- 97% were able to get an appointment to see or speak to someone the last time they tried (CCG average 84%, national average 85%).
- 92% described the overall experience of their GP surgery as fairly good or very good (CCG average 87%, national average 85%).
- 92% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 81%, national average 79%).

- 41% of patients said that they always or almost always got to see or speak to their preferred GP compared to the CCG average of 33% and the national average of 36%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards which were all very positive about the standard of care received. There were recurring themes throughout the cards that praised the care and support provided by the practice. Patients remarked on friendly and helpful staff and said that they felt involved in their care and treatment and that they were always treated with dignity and respect. One card, although generally positive about the surgery, objected to the patient triage system at the practice.

We spoke with five patients during the inspection and one patient, a Patient Participation Group (PPG) member, before the inspection on the telephone. All six patients said they were happy with the care they received and thought that staff were approachable, committed and caring. All of the patients had been registered with the surgery for a large number of years and had nothing but praise for the practice.

Outstanding practice

We saw several areas of outstanding practice including:

- The practice pharmacist had developed a risk-profiling tool to identify patients who were most in need of having their medications reviewed by the practice staff. The pharmacist continued to audit this work to ensure that risks were reduced and we saw evidence of this.
- One of the practice GPs received direct alerts from the police when they had a concern regarding a vulnerable patient. This enabled the GP to arrange an appointment or visit the patient. The practice was the pilot site for this project.
- A charity providing memory screening for patients attended every fortnight and patients were able to self-refer to these clinics as required. The practice also arranged for this charity to attend a flu clinic on a Saturday.
- The practice had purchased a light box to facilitate staff training and hand hygiene. (A light box enables staff to identify poor hand hygiene practices).

Cleveleys Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Cleveleys Group Practice

Cleveleys Group Practice is housed in a purpose built building, Cleveleys Health Centre, situated in a residential area of Cleveleys. The building has been extended to accommodate a growing patient list. The practice provides services to a patient list of 10,965 people. The building is shared with one other GP practice and local community services. District nurses and health visitors have their own rooms within Cleveleys Group Practice.

The practice is part of the NHS Blackpool Clinical Commissioning Group (CCG) and services are provided under a Personal Medical Services Contract (PMS). There are four GP partners (two male and two female) and one female salaried GP. The practice also employs two nurse practitioners, a specialist nurse (a care co-ordinator nurse), three practice nurses, two treatment room nurses, one health care assistant and a pharmacist. The practice is supported by non-clinical staff consisting of a practice manager and fifteen administrative and reception staff.

The practice offers extended hours and is open between 7.30am and 7pm Monday to Friday and Saturday between 8am and 2pm. Appointments on weekdays are offered between 7.40am and 6.50pm and on Saturday between

8am and 1.50pm. When the practice is closed, patients are able to access out of hours services offered locally by the provider Fylde Coast Medical Services by telephoning a local number or 111.

The practice has a considerably higher proportion of patients over the age of 60 when compared to the England average. Figures for patients aged 65 and over show that these patients make up 31% of the practice list compared to the CCG average of 20% and the national average of 17%.

Information published by Public Health England rates the level of deprivation within the practice population group as five on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice caters for a higher proportion of patients experiencing a long-standing health condition (65% compared to the national average of 54%). The proportion of patients who are in paid work or full time education is lower (43%) than the CCG average of 52% and the national average of 62% however unemployed figures are significantly lower, 1% compared to the CCG average of 7% and the national average of 5%.

The practice provides level access to the building and is adapted to assist people with mobility problems. All patient consultations are carried out on the ground floor of the premises and there is a car park on site for patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 3 March 2016. During our visit we:

- Spoke with a range of staff including two GPs, one nurse practitioner, the practice care co-ordinator nurse, the practice pharmacist, the practice manager, a practice nurse, a treatment room nurse, a health care assistant and five members of the practice administrative team.
- Spoke with five patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- 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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager or GP of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events. There was a clinical meeting quarterly and annually to provide a formal overview of all events.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. The practice pharmacist had developed a table showing all of the clinical alerts received by the practice, detailing when and how they were actioned. There had been five recorded significant events in the last 12 months. For example, the district nursing team had been used to leaving written requests for medication in reception for the GP to authorise. On one occasion the GP had reason to question the details of the request. This led to concerns regarding the process of requesting prescription authorisations without discussion with the GP. It was agreed that in the future there had to be discussion between the GP and district nurse before the prescription was produced. This new procedure was reviewed to ensure that it was being followed.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. Where appropriate and with patient consent, patient relatives were involved.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns

about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3.

- Notices in the waiting room and in all clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice had purchased a light box to facilitate staff training and hand hygiene. (A light box enables staff to identify poor hand hygiene practices).
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice audited all emergency drugs in the practice, including those kept in the GP bags, at least monthly and the results were discussed at clinical meetings when appropriate. The practice carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice pharmacist carried out audits recommended by the CCG for optimum patient prescribing and also carried out audits when drug safety notices were received in the practice. The pharmacist had designed a spreadsheet that detailed all drug safety alerts received, how and when they were actioned and the results of the actions.

Are services safe?

Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- The practice reported all significant events and incidents online to the CCG using the National Reporting and Learning System (NRLS).
- We reviewed seven personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice had actively reviewed the information provided to women by an external agency and had requested a change to the wording in one of the letters sent out in order to clarify where patients could be screened. This was accepted and the letter changed.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff were trained and employed to be as multi-skilled as practicable so that risks due to staff absence could be minimised. As part of the practice quality improvement plan, any perceived risks to the practice staffing levels were identified in advance and plans put in place. For example, when the practice recognised that only one nurse was formally qualified in the management of respiratory disease, another of the practice nurses was encouraged to prioritise this training so that there were two nurses qualified in this area.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the reception office.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.



Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. For example, the practice lead GP in diabetes amended practice guidelines for the management of diabetes following updates last year from NICE.
- The practice monitored that these guidelines were followed through risk assessments and audits.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.5% of the total number of points available, with 8.7% exception reporting (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed;

- Performance for diabetes related indicators was better than the CCG and national averages. Blood measurements for diabetic patients showed that 88% of patients had well controlled blood sugar levels compared with the CCG average of 85% and national average of 81%. The practice had reported 8.9% of diabetic patients as exceptions compared to the CCG average of 14.1% and the national average of 10.8%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

- 88% of patients with hypertension having regular blood pressure tests had their blood pressure well controlled by the practice, better than the CCG average of 86% and the national average of 84%.
- The practice achieved 100% of the indicators for mental health care, higher than the CCG average of 98% and the national average of 93%. The practice had reported 11% of patients with mental health problems as exceptions compared to the CCG average of 14.8% and the national average of 11.1%.

Clinical audits demonstrated quality improvement.

- We saw evidence of nine clinical audits undertaken in the last two years, six of these were completed audits where improvements were implemented, monitored and then re-audited and one was still ongoing. There were three additional medication audits that provided data to improve practice prescribing, one of which was still ongoing.
- The pharmacist had developed a risk-profiling tool to identify patients who were most in need of having their medications reviewed by the practice staff. The patients who were identified as having the highest risk scores were then prioritised for review, either by the pharmacist or GP, with a view to optimising and possibly reducing medications. As the most vulnerable patients received reviews, their risk scores decreased. The pharmacist continued to audit this work to ensure that risks were reduced and as a measure of effectiveness.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. Two of the GPs carried out research and one of the practice nurses undertook research on two mornings at the practice. We saw a notice in the waiting room encouraging voluntary patient involvement. The CCG organised nurse meetings every two months for clinical staff which practice staff attended.
- Audit findings were used by the practice to improve services. For example, recent action taken as a result included more appropriate prescribing of antibiotics for patients with bronchiectasis. Also, an audit of patients fitted with ring pessaries led to diary entries being placed on all of these patients' computerised medical records so that no pessary changes were missed.
- Information about patients' outcomes was used to make improvements such as reducing the number of unnecessary lumbar spine x-ray referrals to the hospital.



Are services effective?

(for example, treatment is effective)

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The practice had identified lead roles for all clinicians for the management of chronic disease. Each GP led a team which included at least one nurse and member of administration. One of the GPs had a master's degree in the management of diabetes and was assisting the CCG in developing new pathways of care for diabetic patients. Another GP had a diploma in dermatology.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. Education sessions were organised and shared with the neighbouring practice and speakers were organised to attend regular team meetings when appropriate. All staff were trained in dementia awareness.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets was also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. The practice had adapted rooms in the practice to enable district nurses and health visitors to continue to be based in the practice. This enabled the district nurses and health visitors to be practice-specific and therefore ensured continuity of care for patients.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Because of the large numbers of elderly patients at the practice, the CCG chose the practice to be the pilot site for a new service to provide care for patients needing help to manage their health conditions and to prevent hospital admission.

- The practice had identified a gap in service for patients discharged from hospital and in April 2015, the practice employed a full-time care co-ordinator nurse. The care co-ordinator nurse contacted patients when they were discharged from hospital to see whether their admission could have been prevented. The nurse liaised with practice GPs, pharmacist and other clinical staff and community and health and well-being services to ensure that patient care was co-ordinated and arranged a home visit if necessary. At the home visit, the care co-ordinator nurse conducted a full assessment of patient needs and made referrals to other services as necessary. The nurse produced and updated care plans for these patients and shared them with the out of hours service. We saw evidence that, since the co-ordinator appointment in April 2015, patient admissions to



Are services effective?

(for example, treatment is effective)

hospital had decreased by 5% compared to the same period in the previous year. We were told that this model of care was to be adopted by the CCG for other practices.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The practice kept a list of all patients with a Deprivation of Liberty Standards (DoLS) in place. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Supporting patients to live healthier lives

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

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and patients recently discharged from hospital. Patients were then signposted to the relevant service.
- Smoking cessation advice was available from a local support group.
- A charity providing memory screening for patients attended every fortnight and patients were able to self-refer to these clinics as required. This charity also attended on a Saturday morning during a practice flu clinic.
- A mental health counsellor ran regular clinics in the surgery and staff could refer patients to this service. A recent initiative called Supporting Minds enabled patients to self-refer to these when appropriate.

The practice's uptake for the cervical screening programme was 80% which was comparable to the CCG average of 81% and national average of 82%. The practice demonstrated how they encouraged uptake of the screening programme and how they instigated a change to the letter sent to patients who failed to attend their appointment. They also ensured a female sample taker was available. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice reviewed all non-attenders for these programmes and reminded patients of the importance of attending. Attendance figures for women aged 50-70 at breast cancer screening in the last three years were 74% compared to the CCG average of 66% and national average of 72%. 59% of patients aged 60-69 attended for bowel cancer screening in the last 30 months compared to the CCG average of 53% and national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable or better overall than the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100% (CCG percentage range 90% to 97%) and five year olds from 86% to 99% (CCG percentage range 87% to 97%). The practice, together with the health visitor and GP, continued to carry out health checks for babies aged between seven and nine months even though this was no longer funded for the child health-screening programme. This was done in a weekly clinic where any other parents were encouraged to attend without an appointment should they have any concerns. This improved access for all parents and ensured continuity of care. It was felt that it also improved the uptake of child vaccinations and immunisations.

The practice showed us data that evidenced the flu vaccinations that it had performed in the current year 2015-2016, though this was not validated data. We were shown evidence that the flu vaccination rate for the over 65s was 79% at the end of December 2015 which was the highest rate for the CCG at that time.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40-74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 29 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We spoke with five patients during the inspection and one patient, a Patient Participation Group (PPG) member, before the inspection on the telephone. All six patients said they were happy with the care they received and thought that staff were committed and caring. They told us that their dignity and privacy was respected at all times and that they felt involved in choices about their treatment.

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

- 92% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 88% said the GP gave them enough time (CCG average 87%, national average 87%).
- 97% said they had confidence and trust in the last GP they saw (CCG and national average 95%).
- 92% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).

- 94% said the last nurse they spoke to was good at treating them with care and concern (CCG average 93%, national average 91%).
- 91% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%).

Care planning and involvement in decisions about care and treatment

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

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 or above local and national averages. For example:

- 86% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care (CCG and national average 82%).
- 95% said the last nurse they saw was good at explaining tests and treatments, higher than the CCG average of 91% and national average of 90%.
- 90% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87%, national average 85%).

Staff told us that translation services were available for patients who did not have English as a first language. The practice used services offered by the CCG or those online on the internet.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 236 carers, 2% of the practice list and staff had received carers' awareness

Are services caring?

training. The practice was also a member of the local support service for carers, Carers' Support. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card.



Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice was open from 7.30am to 7pm on weekdays and 8am to 2pm on Saturdays for working patients who could not attend during normal opening hours.
- The practice introduced lunchtime and early morning surgeries after conducting a review of patients attending the local open access service. A survey of patients indicated that they preferred to attend the practice early in the morning rather than later in the day. The practice also started to offer Saturday morning surgeries following a further review.
- There were longer appointments available for patients with a learning disability or for those with complex needs. Patients told us that they could make longer appointments if they felt that they needed extra time for a consultation.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions. Children under five years of age were always given a same day telephone or face-to-face consultation with a nurse practitioner or a GP and children under one year old were always seen by a GP on the same day.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately or were referred to an appropriate clinic.
- There were disabled facilities, a hearing loop and translation services available.
- The practice was a pilot site for a project whereby a GP received a direct alert from the police service when they had concerns regarding a vulnerable patient. The GP would then contact the patient and arrange either a face-to-face appointment or a home visit.
- The GPs provided ward rounds for local nursing homes at least once a month. We spoke to two matrons from local nursing homes by telephone prior to the inspection. One matron told us that the GP visited at least once a fortnight to do ward rounds with staff. This

enabled the GP to carry out any advance planning for end of life patients with the patient and members of their family, telephoning relatives at the time if necessary. We were told that this produced excellent relationships with patients and their families. The matron also said that the surgery knew that if a patient in the nursing home needed an emergency visit, it was always dealt with appropriately and in a timely way. We were told that the home always recommended the practice to new residents as the practice of choice. The second matron told us that the GP visited at least once a month and supported everything that the first matron had told us. The practice told us that a local hospital was to become a nursing home with 58 beds. We were told that it had approached the practice and asked them to register the patients on the practice list because of the practice's reputation with other nursing homes.

Access to the service

The practice offered patient extended opening hours and was open between 7.30am and 7pm Monday to Friday and on Saturday from 8am and 2pm. Appointments were from 7.40am to 6.50pm every weekday and 8am to 1.50pm on Saturdays. In addition to pre-bookable appointments that could be booked up to six weeks in advance, same day and urgent appointments were also available for people that needed them. Due to the lunchtime surgeries provided, there was always a GP on the premises.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment was above the local and national averages in the following areas:

- 94% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 41% of patients said they always or almost always see or speak to the GP they prefer (national average 36%).
- 85% of patients described their experience of making an appointment as good compared to the CCG average of 76% and the national average of 73%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. All patients who expressed a preference said that they could



Are services responsive to people's needs?

(for example, to feedback?)

see the GP that they wanted to in a timely way. We saw that the next routine, pre-bookable appointment was available in two days' time and that there were same day appointments still available.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients. For example, a patient complaint highlighted the fact that patients with more than one chronic disease had to attend several appointments at the surgery. The practice reviewed how these appointments could be streamlined. It trained a member of clinical staff in the management of the diabetic foot and also amended the format of some health checks to include more assessments at one time. It provided longer appointments for these checks. The practice also arranged an extra time for the collection of blood tests from the surgery to allow later appointments. This reduced the number of appointments that patients with more than one long-standing health condition had to attend.
- The practice had an active virtual patient participation group (PPG). They consulted this group regularly when considering changes to practice such as access to appointments and providing online services. When the practice looked at improving the telephone system at the practice they involved the PPG. We spoke to a

member of the PPG who said that they could also raise any issue freely with the practice and that it was dealt with appropriately. For example, the PPG representative had raised an issue of access to the booking system arrival screen and hand gel in reception in relation to the siting of some of the chairs and the practice moved the chairs. The PPG member also told us that they had raised another issue regarding the misuse of disabled parking spaces in the car park which the practice had also addressed.

- There was a suggestion box in the patient waiting area for patients to make suggestions.
- 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 and there was a complaints pack for patients available in reception.

There were 11 complaints received by the practice for the period of October 2014 to February 2016. We looked at these complaints and found that they were dealt with in a timely way with openness and transparency. The practice met to review complaints annually, to summarise lessons learned and to look for any trends overall. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, reception staff had made an appointment with a clinician to dress a wound which the clinician was not qualified to do. The patient then had to make another appointment to see another member of staff with the appropriate training. The practice apologised to the patient and gave reception staff further advice and training on what area of expertise each clinician held and what procedures they were able to carry out.

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 a very clear and comprehensive statement of purpose which was published on the practice website and on the practice computer and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
-

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. The practice had identified leads for clinical and administrative areas in the practice.
- Practice specific policies were implemented and were available to all staff both on the practice computer system and in hard copy.
- A comprehensive understanding of the performance of the practice was maintained. To enable this, the practice had produced a performance dashboard. This dashboard included many high level areas of practice, both clinical and administrative and was populated with data from external and internal systems available to the practice. The data then informed a practice quality improvement plan along with feedback from staff meetings, patient feedback and practice surveys.
- Practice performance against the quality improvement plan was monitored. The practice held monthly clinical meetings with members of community services and administration invited when appropriate. Palliative care patients and safeguarding issues were discussed at these meetings. The meetings also included discussion of any significant incidents that had occurred, audit results, drug alerts, changes to clinical guidelines, results from research and patient complaints.
- The practice liaised with other practices and agencies in the neighbourhood to shape services and improve

communication. The practice attended monthly meetings that included representatives from community services, the ambulance service, the police, social services and health and wellbeing workers. The practice also shared education meetings with the neighbouring practice and participated in whole practice learning events every six months.

- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice had also produced a flowchart detailing the incident reporting process for every staff member.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The practice had attained the Royal College of General Practitioners (RCGP) accreditation in 2014. (This award is to reward practice teams who have improved their organisational quality of care to best practice recommended levels).

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place to recognise and manage notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings. There was a separate administration meeting held monthly which informed the clinical meeting.

Are services well-led?

Outstanding



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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. We noted that there were at least two social events held each year to reward staff.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff turnover in the practice was very low and some staff had been with the practice for over 20 years.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. For example, following a patient survey conducted in 2014, the practice understood that patients had difficulty accessing the practice through its current telephone system. The practice upgraded the telephone system, purchased new software and reorganised staff rotas to resolve the situation.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Following feedback concerning the practice computer system, a staff newsletter was produced to advise staff of updates to the system or similar changes. 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 to improve how the practice was run.
- The practice published a patient newsletter to help inform and engage patients.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example:

- One of the practice GPs received direct alerts from the police when they had a concern regarding a vulnerable patient. This enabled the GP to arrange an appointment or visit the patient. The practice was the pilot site for this project.
- The practice was a pilot site for a new service for the CCG to provide care for patients needing help to manage their health condition and prevent hospital admission.
- The practice enabled and supported staff to develop care pathways to improve the quality of care for patients. One of the clinical staff was currently doing an assessment of patients who had long-standing wounds and then producing six-week care plans. This was being done with input from hospital vascular services in order to produce a flowchart for the management of patients with claudication (pain in the legs while walking). The practice aim was to set up a pilot clinic at the practice.
- The practice had appointed a care co-ordinator to reduce hospital admissions for vulnerable patients. We were told that this model of care was to be adopted by the CCG for other practices.
- Two GPs and one nurse were involved in undertaking research.
- There was a proactive approach to developing new ways of providing care and treatment. This was clearly evident in the practice's appointment of a care co-ordinator for patients who had had hospital admissions. It was also evidenced by the practice acting as a pilot site for new patient services and supporting staff to develop new care pathways for wound management.