The Eaglescliffe Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

We carried out an announced comprehensive inspection on 11 August 2015. Overall the practice is rated as outstanding.

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.

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.

- There is a holistic approach to assessing, planning and delivering care and treatment to patients who use the services. The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice joined with a neighbouring practice to improve the care and treatment of patients in older peoples care homes they visited by producing standards of care and with measurable outcomes.
- Staff actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation are proactively pursued.
- The continuing development of staff skills, competence and knowledge is recognised as integral to ensuring high-quality care.
- Patients said they were treated with compassion, dignity and respect and staff went the extra mile when patients required extra support. Information was provided to help patients understand the care available to them. The practice had produced detailed care plans for patients.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they were meeting the needs of their patients. The practice reviewed the Joint Strategic Needs Analysis (JSNA) and local census information to understand and plan services to meet the needs of their patients.
- 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 (PPG).

Summary of findings

- The systems to manage and share the information that is needed to deliver effective care are coordinated across services and support integrated care for people who use the services.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The building was designed to meet the needs of patients. 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. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to raise concerns and ideas.
- There is a systematic approach taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value.
- The leadership drives continuous improvement and staff are accountable for delivering change. There is a clear practice approach to seeking out and embedding new ways of providing care and treatment.

We saw several areas of outstanding practice including:

- The practice had a very good skill mix which included a nurse practitioner and was able to see a broader range of patients than the practice nurse. There was a preceptorship programme in place to support practice nurses employed in the practice.
- The practice had produced detailed care plans for certain conditions such as those with mental illness, older people and other long term conditions. These plans advised clinicians on what they should be monitoring, questions they should ask patients about their condition and when they should refer patients to a consultant or acute care. We saw data that indicated the number of patients accessing mental health out patient's services had decreased since the care plan had been put in place.
- The practice used a screening tool to reduce polypharmacy and the prescribing of medicines that may cause side effects in older people. We saw that there was a reduction in admissions of older people to acute services from the previous year.
- The practice, in collaboration with a neighbouring practice developed Clinical Standards for the care delivered in the care homes they visited. The standards set out what care the patient and staff in the homes should expect and how they would monitor their effectiveness.
- The practice developed a range of templates and guidance for staff in the management of patients not included in Quality Outcome Framework (QOF). Examples of these were the care of patients suffering from coeliac disease, splenectomy and those patients taking novel oral anticoagulants. The templates also provide evidence based information on how these patients should be effectively supported.
- The practice provided a dermatoscopy service. Two GPs had undertaken training to deliver this service. The practice continually reviewed and audited the process to improve in house referrals and the photographing of skin lesions as an accurate record into the patients notes.
- The practice had developed a Memorandum of Understanding for mutual aid and this was updated in 2015. The document describes how the design of primary care estate can improve the resilience of GP provision when challenged. This was developed by the practice and seen as best practice and was adopted widely across practices in the North East and other strategic health authorities as part of the pandemic influenza preparedness plan during 2009/10.

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 to 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.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

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. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. All staff are actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation are proactively pursued. Data showed the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG). The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. The continuing development of staff skills, competence and knowledge is recognised as integral to ensuring high-quality care.

The systems to manage and share the information that is needed to deliver effective care are coordinated across services and support integrated care for people who use the services. There is a holistic approach to assessing, planning and delivering care and treatment to people who use the services. The practice demonstrated the reference to the JSNA and census information to plan future services for their patient groups. The safe use of innovative and pioneering approaches to care and how it is delivered are actively encouraged. The practice has developed additional evidence based templates to cover non QOF areas to ensure patients receive the best care. An example was coeliac disease reviews. The practice is also involved in the development of local and national developments such as emergency planning and sepsis in children.

Are services caring?

Outstanding

The practice is rated as outstanding 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

Summary of findings

compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and CCG to secure improvements to services where these were identified. 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 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 evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. There is a systematic approach taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value. There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to raise concerns and ideas. The practice gathered feedback from patients and it had an active patient participation group (PPG) which influenced practice development. Governance and performance management arrangements are proactively reviewed and reflect best practice. The leadership drives continuous improvement and staff are accountable for delivering change. There is a clear practice approach to seeking out and embedding new ways of providing care and treatment.

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 for the care of older people. The practice had introduced a number of initiatives to improve the care of older people. They had identified an increasing number of older people and organised care to better meet their needs. The practice had initiated a system to address polypharmacy in older people. The practice also used a tool to calculate Anti-Cholinergic Burden Score for each patient over 75. This alerts clinicians to the use of inappropriate medicines for this age group. The Anticholinergic Cognitive Burden Scale alerts clinicians to medicines that should be avoided which may worsen pre-existing conditions such as dementia. The practice was able to demonstrate that this intervention had led to a reduction in the prescribing of certain medicines and the associated side effects.

The practice provided regular ward round visits to the local care homes as part of a scheme initiated by the CCG. In addition to this, the practice worked with a neighbouring practice to devise a Care Home Quality Standard. Measurable outcomes had been agreed to monitor the effectiveness of the agreed quality standards. For example reviewing the percentage of patients who had had a multi-disciplinary follow up assessment after admission within eight weeks. The document also stated what patients and staff in the care home should expect and promotes the best interests of the patient.

The practice had systematically implemented emergency health care plans, avoiding admission plans and do not attempt resuscitation DNAR to reduce burdensome interventions and unnecessary admission to acute care. We saw the information was evidence based and provided guidance to clinical staff. An example of this was when to refer patients for further investigations. We saw evidence of reduced inappropriate admission to acute care for this patient group. The practice also worked collaboratively with community matrons who managed patients in their own homes.

People with long term conditions

Outstanding ☆

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 patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care

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professionals to deliver a multidisciplinary package of care. The practice consequently had low admission and prevalence rates compared with the locality for such conditions such as asthma, chronic heart disease, stroke and diabetes.

Families, children and young people

Outstanding

The practice is rated as outstanding 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. 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. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice was also working with NHS England, the Royal College of GPs (RCGP) and the sepsis trust to develop a structured approach to the recording of physiological findings and features of sepsis. This will be rolled out nationally in the autumn together with advice to parents on what to look out for.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice had recently provided out of area registration for those patients who wished to remain registered with the practice but had moved out of the area.

People whose circumstances may make them vulnerable

Outstanding

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 those with a learning disability. It had carried out annual health checks for people with a learning disability and 60% of these patients had accepted the invitation. It offered longer appointments for people with a learning disability. We saw the practice staff had recently undergone training to improve the management of those patients with learning disabilities.

Summary of findings

The practice regularly worked with multi-disciplinary teams and the community matron in the case management of vulnerable people. It had told 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.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Of the 9181 patients registered with the practice the aim is to provide 550 patients with poor mental health with an individual care plan developed specific to their needs. The practice has offered this to 178 patients, of which139 have had an individual care plan developed specific to their needs. We saw the practice had developed their own detailed care plans for specific mental health conditions and this included advice, guidance and what help and support was available locally for each condition. We saw that patients were being managed well and there was a marked decrease of patients accessing mental health outpatient services this year. Patients experiencing poor mental health had received an annual physical health check and regular reviews. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The rates for dementia diagnosis were 88.5% above the national average of 83.8%.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. 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

The national GP patient survey results published on July 2015 showed the practice was performing above local and national averages. There were 108 responses and a response rate of 39%. This equated to 1.2% of the practice list size.

- 92% find it easy to get through to this surgery by phone compared with a CCG average of 73% and a national average of 73%.
- 99% find the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 73% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 62% and a national average of 60%.
- 89% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 85% and a national average of 85%.
- 100% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 87% describe their experience of making an appointment as good compared with a CCG average of 73% and a national average of 73%.
- 86% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 70% and a national average of 65%.
- 85% feel they don't normally have to wait too long to be seen compared with a CCG average of 65% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards which were all positive about the standard of care received. Reception staff, nurses and GPs all received praise for their professional care and majority of patients said they felt listened to and involved in decisions about their treatment. Patients informed us they were treated with compassion and that staff went the extra mile to provide care when patients required extra support. We also spoke with two members of the PPG who told us they could not fault the care they had received. We received two comment cards were patients told us they felt rushed during their appointment with the GP and would like longer appointments and more explanations from the clinician.

The Eaglescliffe Medical 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 a second CQC inspector, a practice manager specialist adviser and an Expert by Experience

Background to The Eaglescliffe Medical Practice

The practice Eaglescliffe Medical Practice is located in a residential area of Eaglescliffe. There are 9181 patients on the practice list and the majority of patients are of white British background. There are a higher proportion of patients under the age of eighteen years and those over 65 years on the patient list compared the practice average across England. The practice is a training practice managed by a principal GP (female), with a further four GP partners (male and female), one salaried GP (female) and one GP registrar. There is one nurse practitioner, a practice nurse, health care assistant, phlebotomist (all female), a practice and assistant manager, reception and administration staff. The practice is open 08.00 to 18.00, the earliest appointment is 08.00 and the latest is 17.20 Monday to Friday with extended hours once a week until 21.00 on an alternate Monday and Thursday evenings. Patients requiring a GP outside of normal working hours are advised to contact the GP out of hour's service provided by Northern doctors via the NHS 111 service. The practice has a General Medical Service (GMS) contract.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Detailed findings

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

The inspector :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 11 August 2014
- Spoke to staff and patients.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto the system and responded to appropriately. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a consent form was now sent out with letters inviting patients for childhood immunisations. There was a system in place to constantly monitor the effectiveness of this process.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used an incident reporting system to record and report patient safety and incidents. An example of this was the reporting of missing practice keys which was seen as a security breach. A process was put in place to prevent further security incidents.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children 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.
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were carried out. 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 also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH), infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There 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 arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. The practice also used a screen messaging facility which showed when shared care documents were in place, signed and dated. An example of this was the robust process the practice had developed for managing patients receiving disease-modifying antirheumatic drugs DMARDs
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For

example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

- 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. The practice manager continually monitored this. The practice does not routinely use locum staff, cover is provided by the clinicians doing extra sessions.

Arrangements to deal with 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 treatment room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book 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. We saw that following an emergency in the practice the lead GP had completed a case review reflective diary. This was shared with the practice team and demonstrated good team working.

The practice had developed a Memorandum of Understanding for mutual aid and this was updated in 2015. The document describes how the design of primary care estate can improve the resilience of GP provision when challenged. This was developed by the practice and seen as best practice and was adopted widely across practices in the North East and other strategic health authorities as part of the pandemic influenza preparedness plan 2009/10. The process reviews how the practice would work in partnership with other practices to provide care to patients during extreme circumstances.

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. The practice had identified another practice which they were working with collaboratively to ensure all business continuity plans were effective and robust. The practice had continually reviewed this process with the neighbouring practice. They had established how they would accommodate staff and patients for a period of time. The details also included checking their ability to access their patient records and use their own IT systems.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment 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 ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The maximum QOF points available had been achieved by the practice. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 01/01/2014 to 31/12/2014 showed;

- Performance for diabetes related indicators was better than the CCG and national average. An example is the percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1September to 31 March was 99.6% compared to 93.5% nationally. The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 92% compared to the national average of 88%.
- The percentage of patients with hypertension having regular blood pressure tests was 90% which was above the national average of 83 %.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93.9% which was above the national average of 86%.
- The dementia diagnosis rate was 88.5% which was above the above the national average of 88.3%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been 13 clinical audits completed in the last 24 months, all of these were completed audits which detailed where improvements were implemented and monitored. Examples of these included hormone replacement therapy, review of the prevention and treatment of infection in patients with an absent or dysfunctional spleen and dementia. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, recent action taken following an audit of chronic obstructive pulmonary disease (COPD). As a result it demonstrated the importance of considering a referral for pulmonary rehabilitation and the use of standby medication for this patient group. Additional prompts and codes were added to the template as a reminder for clinicians and to improve the management of the patient.

The Dermatoscopy audit looked at the number of patients who were subsequently referred following dermatoscopy within the practice. The audit identified the number of potential referrals saved was 211 in the first year and 274 in the second. The audit identified the need to improve the photographing of skin lesions as an accurate record into patients notes and improved in house referral to the two trained GPs undertaking dermatoscopy in the practice.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. All staff were given specific roles and responsibilities.
- The learning needs of staff were identified through a system of induction support, appraisals, meetings and reviews of the practices development needs. Staff had access to appropriate training to meet these 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 the revalidation of GPs. All staff had had an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire procedures, and basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

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

Consent to care and treatment

Patients' consent to care and treatment was always sought 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through a system of audit.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. 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 those with complex mental health needs. Patients were then signposted to the relevant service. A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice had also developed additional templates to cover non QOF areas to ensure patients receive the best care. An example was coeliac disease reviews. The templates the practice developed also provided staff with a reminder as to what blood tests needed to be undertaken annually.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 95.7%, which was above the national average of 81.8%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged it's patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.3%% to 98.8% and five year olds from 95.7%to 100%. Flu vaccination rates for the over 65s were 73.59 %, and at risk groups 50.25%. These were also comparable to CCG and national averages.

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 on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. People were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity were maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that 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 41 patient CQC 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. We also spoke with two members of the patient participation group (PPG) on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy were respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was well above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 94% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 95% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 99% patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 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 we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were above local and national averages. For example:

- 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 91% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.

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 this service was available.

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 also had a number of services available within the practice. Examples of these were counsellors, physiotherapy, an alcohol worker and podiatry.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers. Support offered to them included health checks and referral for Social Services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Outstanding ☆

Are services caring?

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, there was evidence of joint working in the management of elderly patients and emergency planning.

- Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example;
- The practice offered evening clinics one day a week until 21.00 for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability and those with complex or more than one long term condition.
- Home visits were available for older patients and those patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available. The colours and design also assisted those patients with sensory loss.
- The practice had installed a lift to improve access, however all consulting rooms where on the lower floor.
- The purpose built building had been designed to provide an entrance area to the practice that provided space and calm for patients. There were large windows, an area for children to play and mothers to breast feed.
- There was adequate car parking available for patients.

Access to the service

The practice was open between 08.00 and 18.00 Monday to Friday. Appointments were from 8.00am every morning to 17.20 daily. Extended hours surgeries were offered on alternative Monday and Thursday with the last appointment at 21.00 9 pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. On the day of inspection pre bookable appointments were available later that week.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mostly above the local and national averages. People we spoke to on the day was able to get appointments when they needed them. For example:

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 92% patients said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 73%.
- 87% patients described their experience of making an appointment as good compared to the CCG average of 73% and national average of 73%.
- 86% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 70% and national average of 65 %.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. It's 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 with posters displayed, and summary leaflets available. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at seven complaints received in the last 12 months and found these were satisfactorily handled, and dealt with in a timely way and learning from the complaint implemented. An example of this was the introduction of consent forms being sent out with childhood immunisation appointments. The lessons learnt from concerns and complaints and action taken as a result to improve the quality of care was shared with staff. We saw that staff at all levels had been involved in developing and implementing and identifying learning. An example was administration staff designing consent forms for childhood immunisations.

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 mission statement which was displayed in the waiting areas and staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values. This was 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 that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

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 that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. 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. Every member of staff we spoke with were positive and enthusiastic about working in the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG raised an issue raised by patients that they did not of know who staff were. The practice in response introduced name badges for all staff. The surveys also identified problems experienced by some patients checking in for appointments at busy times and introduce a screen check-in system. The PPG had identified parking difficulties for patients and this had been addressed by providing dedicated spaces near the entrance to the building. They had also identified that a post box situated opposite the entrance and exit of the practice car park was a potential accident risk, to patients and the public and had successfully arranged for this to be moved.

The practice gathered feedback from staff through annual appraisals, staff meetings, mentoring and discussions with staff. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They told us they felt supported and encouraged and several staff had been supported to continue with further training and development. Examples of these were staff completing diplomas in management and intensive training packages for new staff to ensure they possessed the skills the practice required of them. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

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 the practice works closely with five other practices to

Are services well-led?

Outstanding ☆

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

improve Polypharmacy. Clinicians in the practice were involved in local and national developments such as emergency planning and the improved management of sepsis in children.

The practice collaborated with a local practice to develop Care Home Clinical Standards. This outlined for staff and patients in the care homes what care will be provided by the practice. It also provides information and up to date guidance to clinical staff managing this group of patients and indication for referral to other services. Measurable outcomes were identified to regularly monitor the performance and effectiveness.

The practice developed a range of templates and guidance for staff in the management of patients not included in QOF. Examples of these were the care of patients suffering from coeliac disease, splenectomy and those patients taking novel oral anticoagulants.

The practice had developed detailed care plan templates for those patients with mental health problems. The care plans were multidisciplinary and agency and completed in partnership with the patients. They provided support and guidance to clinicians and patients and where and how help could be provided.

The practice was a training practice and one of the GPs was a GP appraiser. Another GP leads at National level for pre hospital care, emergency care and preparedness and the sepsis prevention programme. We saw the practice was involved with the CCG and shared with other practices innovations they had introduced or were aware of at national level.