Waterside Medical Centre

Quality Report

Court Street
Leamington Spa
CV31 2BB
Tel: 01926 428321
Website: www.watersidemc.nhs.uk

Date of inspection visit: 3 and 11 May 2016
Date of publication: 01/11/2016

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	9
What people who use the service say	13
Outstanding practice	13

Detailed findings from this inspection

Our inspection team	15
Background to Waterside Medical Centre	15
Why we carried out this inspection	15
How we carried out this inspection	15
Detailed findings	17

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Waterside Medical Centre on 3 and 11 May 2016. The overall rating for this service is outstanding.

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

- Patients' needs were assessed and care was provided to meet those needs in line with current guidance. Staff had the skills and expertise to deliver effective care and treatment to patients, and this was maintained through a programme of continuous development to ensure their skills remained current and up-to-date.
- Information was provided to help patients understand the care available to them. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There was an open and transparent approach to reporting and recording these and learning was shared with staff at meetings relevant to their roles and responsibilities.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- A staff briefing newsletter was produced weekly which encouraged staff to complete their online training.
- The practice had a clear vision which had quality and safety as its top priority. Planning was in place to demonstrate the intended development of the services provided by the practice.
- The practice had recognised that 15% of their patients had problems with obesity and associated lifestyle problems. They had participated in a pilot activity project for high risk patients such as those with diabetes, who had suffered a stroke, chronic heart disease or obesity with positive results.
- The practice had initiated weekly journal meetings with all clinicians to ensure that improvements made as a result of the reviews were shared and monitored. Two other local practices joined these meetings to enable wider cross practice learning and information sharing.

Summary of findings

- Monthly newsletters were produced for patients with mental health concerns which promoted support services they could access.
- There was a strong focus on continuous learning and improvement at all levels, with involvement in research and engagement in pilot opportunities.

We saw several areas of outstanding practice including:

- The practice worked with Warwickshire College to provide apprenticeships at the practice. The practice had extended their role in becoming an ambassador for apprenticeships working with Health Education England and the National Skills Academy both locally and nationally. This involved taking part in activities to promote the employment of apprentices. Promotional videos had been completed by the practice staff at the academy for this.
- The practice had initiated and produced birthday cards for patients reaching their 40 and 75 birthdays to raise awareness of health checks and remind patients of the benefits of these. The birthday cards had been shared and adopted by other local practices. The practice had performed over 2,500 health checks since the promotion began in late 2013 and records showed that they had maintained the top practice position within the local area since.
- Facilities were available for patients who had hearing impairments. They were routinely given a double appointment; sign language interpreter services were available; the patient call system was audio and visual; and all signs in the reception and waiting area had been produced in Braille.
- The practice had recently devised a practical guide for clinicians on the management of Vitamin D deficiency and shared this with other 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 learned were shared throughout the practice at regular meetings so that improvements were made and monitored. When there were unintended or unexpected safety incidents, patients were given an explanation and were told about any actions taken to improve processes to prevent the same thing happening again.
- The practice had initiated weekly journal meetings with all clinicians to ensure that improvements made as a result of the reviews were shared and monitored. Two other local practices joined these meetings to enable wider cross practice learning and information sharing.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Staff had received training relevant to their role.
- Appropriate recruitment procedures were followed to ensure that only suitably qualified staff were employed to work at the practice.
- The practice had specific medicine packs available should these be needed in an emergency. These included treatment for the heart, for meningitis, and for anaphylaxis (allergic reaction). Laminated information sheets provided guidance for clinical staff to follow with details of the medicine, its use and recommended treatment dose for each medicine/emergency situation.

Are services effective?

The practice is rated as outstanding for providing effective services.

Outstanding

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There were systems in place to ensure all clinical staff kept up to date. All staff received appraisals and had personal development plans in place. A staff briefing newsletter was produced weekly which encouraged staff to complete their online training.

Summary of findings

- A programme of audits and reviews were carried out so that improvements were made to enhance patient care.
- Data from the Quality and Outcomes Framework (QOF) showed results for patient outcomes were above average when compared with the local and national averages: 90% of patients with hypertension (high blood pressure) had a blood pressure test during the past year which was above the Clinical Commissioning Group (CCG) and the national averages of 86% and 84% respectively. The exception rate for the practice was 3% which was in line with the CCG average of 3% and the national average of 4%.
- The proportion of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 93% which was well above the CCG average of 85% and the national average of 84%.
- Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared.
- The practice had recently devised a practical guide for clinicians on the management of Vitamin D deficiency and shared this with other practices.
- Local practice group meetings were held at the practice, the focus of which was mainly education and learning (including reflective practice).
- Monthly newsletters were produced for patients with mental health concerns which promoted support services they could access.
- The practice worked with Warwickshire College to recruit apprenticeships to the practice with positive results. An apprentice had recently been awarded the Health Education England Primary Care Apprentice of the Year (2016). The practice had extended their role in becoming an ambassador for apprenticeships working with Health Education England and the National Skills Academy both locally and nationally.
- The practice actively promoted health checks for their patients and used a variety of communication methods to achieve this, such as text messages, emails, through the information screens in the waiting area and through birthday cards sent to patients when they reached 40 and 75 years of age.
- A dietician based at the practice provided educational sessions for patients. This had been run on a four monthly basis and focused on patients taking dietary supplements. The sessions were open for any patients to drop in and attend for dietary advice and support. Attendance had been good with 14 attendees at the last session.

- The practice held three educational clinics over the past nine months for patients with diabetes. These were used to promote self-monitoring, better control and compliance of their condition, with 48 patients attending.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Staff were calm, polite and very helpful to patients both attending at the reception desk and on the telephone. We saw that patients' were treated with dignity and respect.
- We observed a patient-centred culture.
- Results from the National GP Patient Survey (July 2016) showed that the practice was considered to be in line with or above for results in relation to patients' experience and satisfaction scores on consultations with the GP and the nurse: 92% of patients said the GP was good at listening to them which was in line with the Clinical Commissioning Group (CCG) average of 93% and above the national average of 89%.
- Patients were very complimentary about the practice and commented that staff were very friendly, that they received excellent care from the GPs and the nurses, and could always get an appointment when they needed one.
- Information to help patients understand and access the local services was available.
- The practice proactively identified, promoted and supported carers within the community. They held regular events to share information such as an annual carers day, 'tea, cakes and information' sessions. They offered regular health checks and made referrals for social service support should patients need this.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and the local community in planning how services were provided to meet patients' needs. Meetings were regularly attended with other practices and partner organisations from the locality so that services could be monitored and improved as required.
- Patients said they found they were able to make an appointment with the GPs and that there was continuity of care, with urgent and regular appointments available the same day.

Summary of findings

- The practice was located in purpose-built premises and had good facilities. It was well equipped to treat patients and meet their needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services through annual patient meetings, the Patient Participation Group and patient surveys.
- Patients could access appointments and services in a way and at a time that suited them. Online appointments could be booked up to one week in advance. There were urgent appointments available the same day. Extended hours were available to benefit patients unable to attend during the main part of the working day.
- Monthly newsletters were produced for patients with mental health concerns which promoted support services.
- NHS Health checks had been completed for 2531patients in the last two and a half years and as a result of these checks 46 patients with diabetes had been identified. We saw data produced by the CCG which showed that the practice was the highest achiever for the completion of health checks in the local area for 2015/2016.
- The practice had recognised that 15% of their patients had problems with obesity and associated lifestyle problems. They engaged in a pilot where selected patients were offered the opportunity to participate in a 12 week activity project. The project was in its third year. Positive results had been achieved for 13 patients who had participated during 2016.
- Facilities were available for patients with hearing impairments. They were routinely given a double appointment; sign language interpreter services were available; the patient call system was audio and visual; and all signs in the reception and waiting area had been produced in Braille.
- Data showed that patients' satisfaction with how they could access care and treatment were rated above local and national averages: 86% of patients found it easy to get through to this practice by telephone which was above the Clinical Commissioning Group (CCG) average of 78% and the national average of 73%.
- Information about how to complain was available and easy to understand and evidence showed that the practice had responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders accordingly.

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

Outstanding

Summary of findings

- There was a clear vision and strategy to provide high quality care for all their patients. Staff were clear about the strategy and their role to achieve this.
- There was a clear leadership structure and staff understood their roles and responsibilities.
- There were governance systems in place to monitor, review and drive improvement within the practice.
- The practice was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was encouraged. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- Staff felt supported by management and that everyone at the practice was approachable should they have any concerns.
- The practice had an active Patient Participation Group (PPG) and responded to feedback from patients about suggestions for service improvements. A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.
- There was a strong focus on continuous learning and improvement at all levels, with involvement in research and engagement in pilot opportunities.
- Away days had been held involving all staff at the practice to plan and develop a five year forward plan and to look at ways of making the practice safer.
- The practice was a research ready practice. They routinely took part in primary care research in order to expand knowledge for their staff towards improved services for patients.
- They had delivered training for local residents in emergency resuscitation procedures in conjunction with another agency and at the time of the inspection had seen over 1,000 residents trained. This had been developed further with the completion of a train the trainer programme which had enabled the practice to extend this training to other practice staff locally.

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 patients.

- The practice offered personalised care to meet the needs of the older people in its population. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.
- The practice offered a range of enhanced services, for example, in dementia and end of life care.
- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients.
- GPs provided care and support for patients at a local care home with weekly visits, and responses to urgent heath care needs when required.
- The practice had signed up to the admissions avoidance service, which identified patients who were at risk of inappropriate hospital admission.
- Support and weekly ward rounds were provided routinely for patients who lived in a nearby care home for the elderly.
- Multi-disciplinary meetings for older patients took place. These were attended by a geriatrician, community matrons and consultants.
- A domiciliary flu vaccination service was provided for those patients unable to attend the clinics at the practice.

People with long term conditions

Outstanding

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

- The practice nurses had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Nursing staff had received appropriate training in chronic disease management, for example asthma and diabetes.
- Longer appointments and home visits were available when needed.
- All patients diagnosed with a long term condition had a named GP and a structured annual review to check that their health and medicine needs were being met.
- Clinical staff had close working relationships with external health professionals to ensure patients received up to date care.

Summary of findings

- A dietician based at the practice provided educational sessions for patients. This had been run on a four monthly basis and focused on patients taking dietary supplements. Sessions were open for any patients to attend for dietary advice and support. Attendance had been good with 14 attendees at the last session.
- The practice held three educational clinics over the past nine months for patients with diabetes. These were used to promote self-monitoring, better control and compliance of their condition, with 48 patients attending.
- A self-care area on the practices website was available to help patients address minor ailments as well as providing information to help patients manage their long term conditions.
- Facilities were available for patients with hearing impairments. They were routinely given a double appointment; sign language interpreter services were available; the patient call system was audio and visual; and all signs in the reception and waiting area had been produced in Braille.

Families, children and young people

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

Outstanding

- Same day appointments were offered to all children under the age of five.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Children had access to a play area in the waiting area.
- Childhood immunisation rates for the vaccinations given were comparable to local and national averages.
- 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 accident and emergency attendances.
- The practice’s uptake for the cervical screening programme was in line with local and national averages. Patients were actively encouraged to attend for screening.
- The practice also offered a number of online services including requesting repeat medicines and booking appointments.
- 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.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

- A midwife worked at the practice three days per week to provide services as the practice had a higher than average birth rate in their locality.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working-age patients (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 services that reflected the needs of this age group.
- The practice nurses had oversight for the management of a number of clinical areas, including immunisations, cervical cytology and some long term conditions.
- Health promotion material was accessible at the practice and on its website.
- Repeat prescriptions could be requested online at any time, which was more convenient for patients.
- Patients could sign up to receive text messages for appointment reminders and health care.
- NHS Health Checks were offered by the nursing team, who also gave advice on smoking cessation, weight loss and exercise.
- Flu clinics were held on a Saturday which provided an alternative option for those patients who could not attend during normal surgery hours.

People whose circumstances may make them vulnerable

Outstanding

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

- Staff had been trained to recognise signs of abuse in vulnerable adults and children and the action they should take if they had concerns. There were lead members of staff for safeguarding, and GPs were trained to an appropriate level (level three) in safeguarding adults and children.
- The practice held a register of patients living in vulnerable circumstances including those patients with a learning disability.
- Longer appointments were available for patients with a learning disability. The practice had carried out annual health checks for 100% of the patients on their register (22).

- Clinical staff regularly worked with multidisciplinary teams in the case management of vulnerable patients. Alerts were placed on these patients' records so that staff knew they might need to be prioritised and offered additional attention such as longer appointments.
- The practice engaged in local initiatives to provide additional services such as the Identification and Referral to Improve Safety (IRIS) scheme (a domestic violence and abuse training, support and referral programme). The project provided staff with training to help them with detecting any signs of abuse so patients could be sign-posted to support agencies.
- Palliative care meetings were attended by district nurses and Macmillan care nurses. Staff also worked together 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.

People experiencing poor mental health (including people with dementia)

Outstanding

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

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- 93% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was 8% above the CCG average and 9% higher than the national average.
- Patients experiencing poor mental health were given advice about how to access various support groups and voluntary organisations.
- The GPs and practice nurses understood the importance of considering patients ability to consent to care and treatment and dealt with this in accordance with the requirements of the Mental Capacity Act 2005.There was a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Access to an in-house counsellor and local counselling services provided by the NHS was provided.
- Monthly newsletters were produced for patients with mental health concerns which promoted support services.

Summary of findings

What people who use the service say

The National GP Patient Survey results published in July 2016 showed the practice was performing mainly above local and national averages. There were 283 surveys were sent to patients with 107 responses which represented a response rate of 38%, equal to the national response rate.

- 86% of patients found it easy to get through to this practice by telephone which was above the Clinical Commissioning Group (CCG) average of 78% and the national average of 73%.
- 95% of patients found the receptionists at this practice helpful which was above the CCG average of 89% and the national average of 87%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried which was below the CCG average of 91% and in line with the national average of 85%.
- 85% of patients described their experience of making an appointment as good which was above the CCG average of 81% and the national average of 73%.
- 72% of patients said they usually waited 15 minutes or less after their appointment time to be seen which was above the CCG average of 69% and the national average of 65%.
- 97% of patients said the last appointment they got was convenient which was above the local average of 94% and the national average 92%.

The practice had taken action to improve patients' access to services. Amendments had been made to the reception staff rota in January 2016 so that more staff were available to take patient calls for appointments.

Results from the NHS Friends and Family Test were consistently high. Patients commented on the friendly, efficient and sympathetic service; that they were always able to get appointments; and that they received excellent care.

We asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were all positive about the standard of care received. Patients commented that this was an excellent practice; all staff were very friendly and efficient; the clinics were very efficient and waiting time was very short; reception staff were amazing and not only helpful, but always gave time, listened and were understanding; and the practice provided excellent care.

During the inspection we spoke with a patient, who was also the chair of the Patient Participation group (PPG) known locally as Friends of Waterside. A PPG is a group of patients registered with the practice, who worked with the practice team to improve services and the quality of care. The patient we spoke with and the views expressed on the comment cards told us that patients received excellent care from the GPs and the nurses and could always get an appointment when they needed one. The PPG chair was very complimentary about the practice team and particularly emphasized the open, collaborative way in which the practice worked with the PPG members. They told us they felt their involvement was valued and their efforts to support the practice were appreciated.

We spoke with management staff of the care home the practice served. They told us they were happy with all aspects of the service they received from the practice.

Outstanding practice

- The practice worked with Warwickshire College to provide apprenticeships at the practice. The practice had extended their role in becoming an ambassador for apprenticeships working with Health Education England and the National Skills Academy both locally and nationally. This involved taking part in activities to promote the employment of apprentices. Promotional videos had been completed by the practice staff at the academy for this.
- The practice had initiated and produced birthday cards for patients reaching their 40 and 75 birthdays to raise awareness of health checks and remind patients

of the benefits of these. The birthday cards had been shared and adopted by other local practices. The practice had performed over 2,500 health checks since the promotion began in late 2013 and records showed that they had maintained the top practice position within the local area since.

- Facilities were available for patients who had hearing impairments. They were routinely given a double appointment; sign language interpreter services were available; the patient call system was audio and visual; and all signs in the reception and waiting area had been produced in Braille.
- The practice had recently devised a practical guide for clinicians on the management of Vitamin D deficiency and shared this with other practices.

Waterside Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Waterside Medical Centre

Waterside Medical Centre is located at the end of Court Street in Leamington Spa and has excellent public transport links with bus stops and a train station within short walking distance from the practice. Waterside Medical Centre serves a mixed population from the town of Leamington Spa, the rural villages and hamlets within a five mile radius of the town.

The practice has seen a steady rise in patient numbers over the past five years due to a number of housing developments in the area and patient migration. The current patient population is almost 12,500 and this is expected to rise further on the completion of several large housing developments in the area over the next decade. The majority of patients are aged between 20 and 59 years of age (65%), with ages up to 19 years at 18%, older patients from 60 to 79 years at 13% and patients over 80 years at 4%. The majority of patients registered with the practice are white British with smaller ethnic groups including Asian and Eastern European patients.

There are four GPs partners (two male and two female), two salaried GPs, three nurses and two healthcare assistants, who are all supported by a large team of receptionists and admin staff.

The practice has a General Medical Services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice is also a member of the South Warwickshire GP Federation.

The practice opens from 8am to 6.30pm Monday to Friday with appointments available from those times on these days. Extended hours appointments are available on Monday evenings from 6.30pm to 8.30pm and Saturday mornings from 8.15am to 12.15pm for pre-bookable appointments up to a week in advance.

The practices offers a full range of services to all their patients from their purpose-built premises, and patients can access the practice throughout the day in person, by telephone, by e-mail or via the internet. The practice offers on-line appointment booking, online prescription requests, a text messaging service and full online access to medical records via the internet and an app.

The practice treats patients of all ages and provides a range of medical services. This includes disease management such as asthma, diabetes and heart disease. Other appointments are available for services such as minor surgery, smoking cessation, maternity care and family planning.

The practice does not provide an out-of-hours (OOHs) service but has alternative arrangements in place for patients to be seen when the practice is closed. For example, if patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances or dial NHS 111. Information on the OOHs service (provided by CareUK) is provided to patients on the practice's website and in the patient practice leaflet.

Detailed findings

The practice is a research ready practice. They routinely take part in primary care research in order to expand knowledge for their staff towards improving services for patients.

Why we carried out this inspection

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

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

How we carried out this inspection

Before our inspection of Waterside Medical Centre we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We carried out an announced inspection over two days on 3 and 11 May 2016.

During our inspection we:

- We reviewed policies, procedures and other information the practice provided before the inspection. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.
- Spoke with a range of staff that included three GPs, the practice manager, the reception manager, two practice nurses, a pharmacist and reception and administration staff.
- Looked at procedures and systems used by the practice.
- Spoke with a patient who was also the chair of the Patient Participation Group (PPG). A PPG is a group of patients registered with the practice, who worked with the practice team to improve services and the quality of care.
- We observed how staff interacted with patients who visited the practice, how patients were being cared for and talked with carers and/or family members.
- We reviewed 34 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 asked the following five questions:

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff were encouraged to report all events as part of their everyday role and responsibilities. We saw that both positive and adverse incidents and events had been recorded.
- Staff told us they would inform the practice manager of any incidents and gave us examples where they had reported incidents, the process they had followed and the learning outcomes shared and discussed with them.
- Learning was shared in relevant staff team meetings. Staff confirmed this and that minutes of these meetings were distributed among all staff teams.
- Regular training and review of all events was carried out to ensure that continual learning was promoted and practice improvement was maintained.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

We reviewed safety records, incident reports, national safety alerts and minutes of meetings where these were discussed.

- The practice carried out a thorough analysis of all the significant events and shared learning from these with appropriate staff. For example, 25 incidents had been recorded for last 18 months. Action had been taken to ensure the safety of the practice was maintained and improved.
- The practice had initiated weekly journal meetings with all clinicians to ensure that improvements made as a result of the reviews were shared and monitored. Two other local practices joined these meetings to enable cross practice learning and information sharing.
- Incidents were also shared at the bi-monthly larger buddy group meetings of nine practices. These were attended by a GP and the practice manager.
- Patient safety alerts were received by email from external agencies such as Medicines and Healthcare products Regulatory Agency (MHRA) and the National Institute for Health and Care Excellence (NICE). These were coordinated by the practice manager. All alerts were discussed at practice meetings and at the journal club. Minutes of these meetings had been kept.
- GPs and nurses described examples of alerts where appropriate changes had been made as a result. For example, we saw evidence that recent guidance from NICE on the treatment of women with intermenstrual bleeding (bleeding outside their normal cycle) had been followed. Scans had been introduced with follow up appointments arranged for those patients. Patients were also monitored through the practice's follow up tracker to ensure that processes had been followed, with an audit completed which confirmed this.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe.

- Arrangements were in place to safeguard adults and children from the risk of abuse that reflected relevant legislation and local requirements. Staff told us that all policies were accessible to them and clearly outlined who staff should contact for further guidance if they had any concerns about a patient's welfare.
- GPs and nurses were trained to level three in child and adult safeguarding. Administrative staff had received regular training so they would know how to respond should they have any concerns. A training session on elderly abuse had been presented to the journal club by the practice following guidance from the British Medical Association.
- Staff demonstrated they understood their responsibilities and all had received training relevant to their role. They demonstrated an understanding and shared times when they had raised concerns about patients and the process they had followed. Each incident had been discussed at the clinical journal club meeting to evaluate this.
- The practice maintained a vulnerable patient register which they updated regularly through discussions with the health visitor. Patients on the register included frail elderly, patients with dementia, patients with a drug and alcohol dependency, patients with mental health concerns and homeless patients. The computer system highlighted those patients who were considered to be at risk of harm or who were on the vulnerable patient register.

Are services safe?

- A notice was displayed in the waiting room and in treatment rooms advising patients that chaperones were available if required. All staff who acted as chaperones had been trained for the role and relevant staff had received a disclosure and barring check (DBS). DBS checks identified whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Appropriate standards of cleanliness and hygiene were followed.

- We observed the premises to be visibly clean and tidy. There was an infection control protocol in place and staff had received up-to-date training. Regular infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- A practice nurse was the clinical lead who liaised with the local infection prevention and control 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. Regular infection control audits were carried out and we saw that action was taken to address any improvements identified as a result. The latest audit had been completed in February 2016 with an action plan in place where improvements had been needed.

There were suitable arrangements in place for managing medicines, including emergency medicines and vaccines to ensure patients were kept safe.

- This included obtaining, prescribing, recording, handling, storing and security of medicines.
- Prescriptions were securely stored and there were systems in place to monitor their use. Reception staff confirmed they would alert the GPs to prescription requests when the number of authorised repeats had passed, and when prescriptions had not been collected.
- Processes were in place which included the review of high risk medicines. We reviewed a sample of anonymised patient records where particular high risk medicines had been prescribed. These showed that appropriate monitoring was in place.
- Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw that PGDs and PSDs had been appropriately signed by nursing staff and the lead GPs.
- The practice kept records to confirm staff protection against Hepatitis B.
- There was a sharps injury policy and staff knew what action to take if they accidentally injured themselves with a needle or other sharp medical device. A laminated poster was clearly displayed in treatment rooms to guide staff should this become necessary.
- All instruments used for treatment were single use. The practice had a contract for the collection of clinical waste and had suitable locked storage available for waste awaiting collection.

The practice had appropriate recruitment policies and procedures in place.

- We looked at personnel files for four staff with various roles employed by the practice. All employment checks had been carried out and all recruitment processes had been followed in line with the practice’s policy and legal requirements. For example, proof of identity, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. We saw that appropriate checks were also carried out for the employment of locum GPs.
- The majority of staff worked part time at the practice and this provided flexible working and internal cover for periods of absence. Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients’ needs. There was a rota system in place for the different staff groups to ensure that enough staff were available each day. Staff confirmed they would also cover for each other at holiday periods and at short notice when colleagues were unable to work due to sickness.

Monitoring risks to patients

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 in the reception office.

- All electrical equipment and clinical equipment had been checked in May 2015 to ensure it was safe to use with the next check due in May 2017. Staff confirmed these checks were carried out routinely.

Good

Are services safe?

- The practice also had various other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection prevention and control (IPC) and Legionella (a bacterium which can contaminate water systems in buildings).
- The practice had an up-to-date fire risk assessment in place and a fire evacuation drill took place annually. Staff described the action they would take in the event of a fire alarm and confirmed they had completed fire training. Records confirmed that all staff had completed this training.

Arrangements to deal with emergencies and major incidents

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

- A business continuity plan (updated in January 2016) was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This plan was initially developed through workshops with all staff and during discussions at staff meetings. The plan contained relevant contact details for staff to refer to which ensured the service would be maintained during any emergency or major incident. There was a staff help guide on the practice's intranet which gave all staff quick access to all parts of the plan. All relevant staff held hard copies of the plan at home.
- Staff had access to an instant messaging system on the computers in all of the consultation and treatment rooms which alerted other staff to any emergency. There were also alarm buttons in reception should assistance be needed in the waiting area.
- All staff received annual basic life support training.
- There were emergency medicines and equipment available as required, including a first aid kit and accident book. These were easily accessible in a secure area of the practice and all staff knew of their location. Medicines included those for the treatment of cardiac arrest (where the heart stops beating), a severe allergic reaction and low blood sugar. All the medicines we checked were in date and stored securely.
- Oxygen and a defibrillator (used to help restart the heart in an emergency were available and these had been regularly checked and maintained.
- A laminated information sheet was provided for clinical staff which listed the medicine, together with use and recommended treatment dose for each medicine or emergency situation. There were also specific emergency packs made up for clinical staff to access for emergency treatment for the heart, for meningitis, and for anaphylaxis (allergic reaction).

Outstanding

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.

- There were systems in place to ensure all clinical staff kept up to date. They had access to best practice guidance from the National Institute for Health and Care Excellence (NICE) and used this information to develop how care and treatment was delivered to meet patients' needs. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment.
- Local practice group meetings were held at the practice, the focus of which was mainly education and learning (including reflective practice). Discussions included best practice such as updated cancer care guidance and NICE guidance. The practice had recently devised a practical guide for clinicians on the management of Vitamin D deficiency and shared this with other practices. These meetings were intended to provide professional development. Guest speakers attended to provide skill and knowledge updates.
- Regular routine meetings were held three times each week for each practice staff group.

Management, monitoring and improving outcomes for patients

The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK intended to improve the quality of general practice and reward good practice. QOF data showed the practice achieved 100% of the total number of points available compared with the local average of 98% and the national average of 95%.

Data showed that the practice achieved rates that were above the local and national averages.

- 90% of patients with hypertension (high blood pressure) had a blood pressure test during the past year which was above the Clinical Commissioning Group (CCG) and the national averages of 86% and 84% respectively. The exception rate for the practice was 3% which was in line with the CCG average of 3% and the national average of 4%.
- The proportion of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 93% which was well above the CCG average of 85% and the national average of 84%. The exception rate for the practice was 8% which was in line with the CCG and national averages of 6% and 8% respectively.
- Performance for diabetes related indicators such as patients who had received an annual review including foot examinations was 91% which was in line with the CCG average of 92% and above the national average of 88%. The exception rate for the practice was 6% which was in line with the CCG average of 5% and lower than the national average of 8%.
- Patients with mental health concerns such as schizophrenia, bipolar affective disorder and other psychoses with agreed care plans in place were 100% which was well above the local and national averages of 93% and 88% respectively. The exception rate for the practice was 21% which was above the CCG and national averages of 11% and 13% respectively. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition.

The practice recognised the challenges for their patients with mental health concerns and their relatively high exception reporting rates. They had worked with the local CCG to develop a business case for more mental health support services to be based at the practice to promote more proactive support for this patient group. The pilot proposal was approved and was due to commence on Monday 5th September 2016. The pilot was a collaboration between the CCG, Warwickshire County Council and ReThink Mental Health with mental health support workers supported by Department for Work and Pensions (DWP) staff and social prescribing staff based at the practice two full days a week dedicated to providing proactive and responsive care to these patients.

The practice was proactive in their approach to their patients with mental health concerns:

Outstanding

Are services effective?

(for example, treatment is effective)

- They recalled each patient for their annual review with up to three letters but also proactively booked these patients an appointment for a blood test followed by a review with their regular GP. They found that patients were more likely to attend if the appointment had already been made for them.
- They followed up with text reminders and immediate contact with the patient if they failed to attend their appointments.
- They worked closely with the substance misuse services located nearby and the mental health teams to proactively support these patients and help them understand the importance of regular formal reviews.
- All records of patients with mental health concerns were flagged on their patient record system to promote opportunistic review throughout the year.
- Monthly newsletters were produced for patients with mental health concerns which promoted support services they could access.

The practice carried out regular quality audits to monitor and identify where improvements could be made.

- The practice had carried out 10 completed cycle clinical audits in the last two years, with improvements made and monitored. This included a review of anti-rheumatic medicines where improvements were made to patient monitoring and medicine review processes.
- The practice participated in applicable local audits, national benchmarking, accreditation, and peer review. There was a cross CCG buddy system of 39 practices in place which were divided into buddy groups. The practice's group of nine practices regularly reviewed issues such as prescribing, medicines management and referrals.
- QOF and CCG benchmarking was used to monitor the practice's performance. The practice also carried out audits in response to data provided by the CCG. These were discussed at practice journal club meetings and changes identified by the data were shared. Follow up audits ensured changes had become embedded.

Effective staffing

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

- The practice used a system of appraisals, meetings and reviews of practice development to identify the learning needs of staff.
- Staff told us they had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, clinical supervision and facilitation.
- All staff had received an appraisal within the last 12 months and had a personal professional development plan in place.
- Staff received training that included basic life support, safeguarding, fire procedures, infection control and mental health awareness. Staff had access to and made use of e-learning training modules and in-house training.
- Support and encouragement was provided for staff to complete additional training. For example, practice nurses had recently completed additional training to enhance their roles.
- Staff confirmed that protected learning time was made available for all staff.
- There was an induction programme in place for newly appointed non-clinical members of staff. The schedule covered topics such as complaints, safeguarding, fire safety, health and safety and confidentiality. Staff were also introduced to the staff review and appraisal system as routine when they started to work at the practice.
- The practice continually encouraged staff development. In 2015 the practice had implemented daily work sheets completed by all staff to enable evaluation of job roles and responsibilities. As a result all reception staff were provided with additional training and rotas were adjusted to ensure staffing levels matched demand from patients. A key element of this work was the detailed mapping of activity by hour of day to determine resource levels and skill mix requirements which led to the improvements. Staff confirmed they were happy with this process and had found this beneficial both in recognition of the work they did and in improving services for patients.
- A staff briefing newsletter was produced weekly which encouraged staff to complete their online training.
- The practice worked with Warwickshire College to provide apprenticeships at the practice. One apprentice had moved on to complete a university degree in business studies. Another apprentice had recently been awarded the Health Education England Primary Care Apprentice of the Year (2016). The practice had extended their role in becoming an ambassador for apprenticeships working with Health Education England and the National Skills Academy both locally and

nationally. This involved taking part in activities to promote the employment of apprentices. Promotional videos had been completed by the practice staff at the academy for this.

Coordinating patient care and information sharing

Staff had access to the information they needed to plan and deliver care and treatment through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results.

Regular meetings were held to maintain patients wellbeing and ensure coordinated care:

- Multi-disciplinary meetings for older patients took place. These were attended by a geriatrician, community matrons and consultants.
- Palliative care meetings were attended by district nurses and palliative care nurses. Staff also worked together 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.
- Monthly meetings were held with health visitors.

The practice had produced a monthly newsletter for many years in which information was shared with patients. We saw copies of the newsletters as far back as January 2014 which had covered a range of topics such as:

- Health awareness campaigns including mental health, sexual health, autism, nutrition and hydration, male cancer, diabetes and cervical cancer. Details for further contact and advice were given.
- Musical memories café for patients living with dementia and details about community transport for health appointments.
- Practice staff news, long service achievements and new appointments; as well as advice for dealing with minor ailments such as insect bites.
- Service reminders for NHS health checks, screening and useful contact numbers were included.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance.

- We saw evidence of written consent given by a patient in advance of minor surgery that confirmed this. Minor surgery audits were carried out routinely and included an assessment of completed consent.
- Clinical 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 patients assessments of capacity to consent were also carried out in line with relevant guidance.
- The GPs and practice nurses understood the need to consider Gillick competence when providing care and treatment to young patients under 16. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
- Where a patient's mental capacity to consent to care or treatment was unclear the GPs or nurses assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice had numerous ways of identifying patients who needed additional support and was pro-active in offering help.

- Staff told us that being a small practice they got to know their patients well and were able to use this knowledge and their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, they would carry out opportunistic medicine reviews, encourage patients to attend for screening or immunisations, and encourage patients to sign up to the carers register.
- The practice kept a register of all patients with a learning disability and ensured that longer appointments were available for them when required.
- At the time of the inspection there were 22 patients with a learning disability registered with the practice. Accessible care plans were in place to help patients with their general health and well-being. Regular reviews of their care were carried out and all these patients had received a review for the previous year.

The practice nurses carried out health checks for all new patients registering with the practice, to patients who were 40 to 70 years of age and also some patients with long term conditions. The NHS health check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes

over the next 10 years. The practice followed up patients within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations.

The practice had systems in place to promote health checks. They had:

- Produced a practice newsletter.
- Used their website and social media sites to raise awareness about health checks.
- Used information screens in the waiting area.
- Instigated text message and email reminder campaigns.
- Reminder messages were added to patient records and regular audits were carried out to check that all eligible patients had been encouraged to participate.
- Initiated and produced birthday cards for patients reaching their 40th and 75th birthdays to raise awareness of health checks and remind patients of the benefits of these. The practice told us that the birthday cards had been shared with and adopted by other local practices.

The practice had performed over 2,500 health checks since the promotion began in late 2013 and records showed that they had maintained the top practice within the local area since. The practice had evaluated the impact of the health checks for these patients. For example:

- 46 patients had been diagnosed with diabetes
- 139 had been diagnosed with high blood pressure
- 25 patients had been diagnosed with chronic kidney disease
- 67% of patients had been referred to a lifestyle service.

The practice had a comprehensive screening and vaccination programme:

- The practice’s uptake for the cervical screening programme at 75% was in line with the CCG and the national averages of 77% and 74% respectively. Records showed that there had been no inadequate samples taken during the last year.
- Childhood immunisation rates for vaccinations given were overall comparable with the local CCG averages. For example, rates for the vaccinations given to children up to 12 months ranged from 95% to 96% which were comparable with the CCG rates of 97%.
- The practice’s uptake for the bowel screening programme in the last 30 months was 61% which was in line with the local average of 64% and above the national average of 58%. Uptake for breast screening for the same period was in line with local and national averages at 75% compared with 75% and 72% respectively.
- A dietician based at the practice provided educational sessions for patients. This had been run on a four monthly basis and focused on patients taking dietary supplements. Sessions were open for any patients to attend for dietary advice and support. Attendance had been good with 14 attendees at the last session.
- The practice held three educational clinics over the past nine months for patients with diabetes. These were used to promote self-monitoring, better control and compliance of their condition, with 48 patients attending.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spent time in the waiting area talking with patients and observing how staff engaged with patients.

- All staff were polite, friendly and helpful to patients both attending at the reception desk and on the telephone. We observed that patients were treated with dignity and respect.
- Curtains were provided in consultation rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.
- We saw that doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff told us that when patients wanted to discuss sensitive issues they would offer a private room to discuss their needs. There was a poster in the waiting room which informed patients of this facility.

The 34 comment cards we received were positive about the standard of care received. Patients commented that Waterside Surgery:

- Was an excellent practice.
- All staff were very friendly and efficient; the clinics were very efficient and waiting time was very short; reception staff were amazing and not only helpful, but always gave time, listened and were understanding; the practice provided outstanding care.
- A patient we spoke with confirmed the positive comments given in the comment cards, that patients received excellent care from the GPs and the nurses and could always get an appointment when they needed one.

Results from the National GP Patient Survey published in July 2016 showed that the practice achieved results that were mainly in line with or above local and national rates in relation to patients' experience of the practice and the satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients said the GP was good at listening to them which was in line with the Clinical Commissioning Group (CCG) average of 93% and above the national average of 89%.
- 83% of patients said the GP gave them enough time which was below the CCG average of 91% and above the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw or spoke to which was in line with the CCG average of 98% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern which was below the CCG average of 89% and in line with the national average of 85%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern which was above the CCG average of 92% and the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful which was above the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they were involved in decisions about their care and treatment:

- Patients said that health issues were discussed with them and they felt involved in decision making about the care and treatment they received.
- They said 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.
- Patients gave us examples of how the practice communicated with them. For example, patients told us the practice would send for them if there were any concerns from blood tests results.
- Patients commented that they felt that GPs and nurses were very attentive, caring and professional and made sure they were well cared for.

Results from the National GP Patient Survey published in July 2016 showed:

- 89% of patients said the last GP they saw was good at explaining tests and treatments which was in line with the CCG average of 91% and above the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care which was in line with the CCG average of 87% and above the national average of 82%.

Good

Are services caring?

The practice provided support so that patients could be fully involved in decisions about their care.

- Care plans were in place for patients with a learning disability (easy read), and for patients who were diagnosed with asthma, dementia and mental health concerns.
- GPs demonstrated knowledge regarding best interest decisions for patients who lacked capacity. They told us that they always encouraged patients to make their own decisions and obtained their agreement for any treatment or intervention even if they were with a carer or relative. The nurses told us that if they had concerns about a patient's ability to understand or consent to treatment, they would ask their GP to review them.
- Minutes of various meetings held to discuss patients' care needs demonstrated liaison with other agencies to support patients with their care. For example, weekly meetings were held to review and plan end of life care with key partners and were attended by practice staff, district nurses and Macmillan nurses.
- Translation services were available for patients who did not have English as a first language. Patients were also offered the services of a sign language interpreter if required. Notices in the reception areas informed patients this service was available.

Patient and carer support to cope emotionally with care and treatment

The practice supported patients and carers in a number of ways:

- Notices and leaflets were available in the patient waiting room with information on how to access a number of support groups and organisations.
- Staff told us that if families had experienced bereavement the GP telephoned them and often sent bereavement cards to them.
- Feedback from patients showed that they were positive about the emotional support provided by the practice.
- Patients said that staff had been caring and considerate when they needed help and provided them with support.
- The practice worked with other professionals proactively to support those patients considered at risk such as older patients, patients experiencing poor mental health and families at risk of isolation to receive both practical and emotional support when needed.

The practice maintained a register of those patients who were also carers, with the practice's computer system alerted GPs if a patient was also a carer.

- There were 152 carers registered with the practice (1.5% of the practice population).
- The practice held carers events annually and planned to run a campaign in June 2016 to identify more carers, and encourage more use of their website, social media and text messaging services.
- There was a dedicated notice board display and information screens with information about carer support.
- The practice promoted the use of a carer's emergency card, which had been developed by Warwickshire County Council, NHS Warwickshire and Guideposts Carer Support Service. The card provided contact details should a carer needed support in an emergency.
- Information about carer support and the carer register were promoted through the practice monthly newsletter made available for patients.
- The practice supported patients who were carers by offering health checks and referrals for social services support.
- The practice held a carers 'tea, cakes and information' event in 2015 which was well attended and patients gave positive feedback.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

Services were planned and delivered to take into account the needs of different patient groups to ensure flexibility, choice and continuity of care.

- Urgent access appointments were available for children and those with serious medical conditions. GPs told us that urgent appointments were available every day and confirmed that patients would always be seen. Staff described how they would respond to patients in need of urgent care.
- The practice operated an appointment system which provided early, late, on the day, a week in advance and duty GP appointments for patients.
- GPs made home visits to patients whose health or mobility prevented them from attending the practice for appointments. Longer appointments were available for patients with specific needs or long term conditions such as patients with a learning disability.
- Annual reviews were carried out with patients who had long term conditions such as diabetes and lung diseases, for patients with learning disabilities, and for those patients who had mental health problems including dementia. The GPs and the nurses told us they shared information with patients to help them understand and manage their conditions. Patients commented that GPs and nurses took the time to explain their treatment and listened to any concerns they had.
- Saturday flu clinics combined with charity coffee mornings were arranged to encourage attendance for the vaccination.
- Children had access to a play area in the waiting area.
- A self-care area on the practices website was available to help patients address minor ailments as well as providing information to help patients manage their long term conditions.
- Access to an in-house counsellor and local counselling services provided by the NHS was provided.
- Monthly newsletters were produced for patients with mental health concerns which promoted support services.
- Three experienced smoking support advisors worked at the practice and encouraged patients to quit smoking. The practice won an award as the best practice for this service in South Warwickshire for 2015/2016. Staff told us their 80% success rate had been due to their open and honest approach with patients which had encouraged and supported them through the process.
- A domiciliary flu vaccination service was provided for those patients unable to attend the clinics at the practice.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice was responsive to the needs of patients with a long term condition and operated a recall system to ensure all patient care was monitored appropriately. For example, the practice had introduced three monthly and six monthly blood tests for patients to ensure their diabetes was under control. The practice had achieved a higher number of reviews completed for patients diagnosed with dementia than the local and national averages.
- The practice had a higher than average birth rate in their locality and to ensure needs were being met a midwife worked at the practice three days per week to provide services for this patient group.
- They worked in an integrated way with multidisciplinary teams in South Warwickshire. They held monthly meetings to focus on patients aged over 75 years to plan care to reduce the likelihood of admission to hospital of patients with long term conditions. Comprehensive assessments had been carried out for 354 patients and they had seen a 9.3% reduction in emergency hospital admissions for these patients for 2015/2016.
- NHS Health checks had been completed for 2531patients in the last two and a half years and as a result of these checks 46 patients with diabetes had been identified. We saw data produced by the CCG which showed that the practice was the highest achiever for the completion of health checks in the local area for 2015/2016.
- The practice engaged in local initiatives to provide additional services such as the Identification and Referral to Improve Safety (IRIS) scheme (a domestic violence and abuse training, support and referral programme). The project provided staff with training to help them with detecting any signs of abuse so patients could be sign-posted to support agencies.

The practice had recognised that 15% of their patients had problems with obesity and associated lifestyle problems.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice embarked on a partnership with Coventry Solihull and Warwickshire (CSW) Sport, Sport England, Warwickshire County Council Fitter Futures team and the University of Warwick. High risk patients such as those with diabetes, who had suffered a stroke, chronic heart disease or obesity, were offered the opportunity to participate in a 12 week activity pilot, which was in its third year.
- This pilot offered a wide range of sports including golf, swimming, walking, football, horse-riding or sailing. The practice told us that patients achieved positive results for 2016 programme.
- All 13 participants completed the programme. Patients lost a combined weight of 2.3kg in weight; they decreased their body fat by 3.23%; patients recorded decreased blood pressure rates; and increased their physical activity by 50 minutes per week.

Access to the service

- The practice treated patients of all ages and provided a range of medical services. This included a number of disease management clinics such as asthma, diabetes, and heart disease. The practice offered routine ante natal clinics, childhood immunisations, travel vaccinations and cervical smears. A minor surgery service was provided by the practice.
- The practice opened from 8am to 6.30pm Monday to Friday with appointments available from these times. There was flexibility of appointments for all patients as all GPs worked full time to ensure all patients had access to appointments to ensure continuity of care.
- Extended hours appointments were available between 6.30pm and 8.30 pm on Monday evenings and Saturday mornings from 8.15am to 12.15pm for pre-bookable appointments up to a week in advance. The extended hours appointments were to help patients who found it difficult to attend during regular hours, for example due to work commitments.
- Information was available to patients in the practice leaflet and on the website for when the practice was closed. Patients were advised to telephone NHS 111 in the first instance or contact the OOHs service (provided by CareUK).
- Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments, home visits and order repeat prescriptions. Patients could access the practice throughout the day in person, by telephone, by e-mail or via the internet. The practice offered on-line appointment booking, online prescription requests, a text messaging service and full online access to medical records via the internet and an app.
- Facilities were available for patients with hearing impairments. They were routinely given a double appointment; sign language interpreter services were available; the patient call system was audio and visual; and all signs in the reception and waiting area had been produced in Braille.
- Vulnerable patients were supported to register with the practice, such as homeless people or travellers.

Home visits were available for patients who were too ill to attend the practice for appointments. The practice had a GP triage system in place to assess whether a home visit was clinically necessary and the urgency for medical attention. In urgent cases alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Results from the National GP Patient Survey published in July 2016 showed that patients' satisfaction with how they could access care and treatment were rated above local and national averages. For example:

- 86% of patients found it easy to get through to this practice by telephone which was above the Clinical Commissioning Group (CCG) average of 78% and the national average of 73%.
- 85% of patients described their experience of making an appointment as good which was above the CCG average of 81% and the national average of 73%.
- 72% of patients said they usually waited 15 minutes or less after their appointment time to be seen which was above the CCG average of 69% and the national average of 65%.

Patients gave positive views about the appointments system. We received 34 comment cards and spoke with one patient, all of whom were very positive about access to and the availability of appointments at the practice. Patients commented that getting appointments and waiting times was never a problem and they could always see a GP if the appointment was urgent. On the day of the inspection all calls had been triaged to an appointment with no queries or waiting by patients.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

Social media was used by the practice and they had 1,786 followers on Twitter. The practice also used their website to promote self-care including the use of over the counter medicines for patients. The practice had recently launched a mobile app which they planned to encourage patients to use.

Listening and learning from concerns and complaints

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

- Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice. They confirmed they made contact with the patient as soon as possible following receipt of any complaint.
- There was an open and transparent approach towards complaints. Information about how to make a complaint was accessible to patients on the practice's website and in a complaints leaflet that was made available at the practice.
- Patients told us that they were aware of the process to follow should they wish to make a complaint, although none of the patients who completed comment cards had needed to make a complaint.
- Staff told us they would encourage patients to speak with the practice manager if they were unhappy with anything at the practice in the first instance.
- Complaints were reviewed annually. We saw complaints for the period April 2015 to March 2016 in which 12 complaints had been received. The analysis showed that no themes or patterns had been identified. We found complaints had been dealt with promptly with responses to and outcomes of the complaints clearly recorded. Overall learning from the annual review of complaints was shared with all staff at the relevant team meetings. We saw minutes of meetings that confirmed this.
- Staff gave examples of changes implemented as a result of a complaint. For example, ultrasound scanning requests were now faxed to the hospital and the acknowledgement was scanned into patients' notes as a result of changes made.
- A complaints folder was kept in reception so that details of verbal complaints could be captured to identify potential themes before they became significant issues.

Are services well-led?

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

Our findings

Vision and strategy

The practice described the patient-centred ethos of the practice. Staff we spoke with confirmed that they worked to deliver a standard of service that reflected this ethos.

- Delivering the right patient care, in the right place, at the right time, through a skilled and committed workforce. This would be done in partnership with local health economies.
- The practice told us they were passionate and proactive about the services they provided.

The practice had a five year forward plan in place which all staff had been involved in discussions at annual away days to develop this.

- Away days provided the practice staff with opportunities for strategic review and planning. The last practice away day had been organised in 2015 which was attended by all staff with an agenda of making the practice safer. A further away day was planned for July 2016. Minutes of these meetings were available and we could see how all members of the staff were encouraged to offer suggestions for future development and improvement to the practice.

The practice had identified their future challenges as:

- The pace of change within the NHS.
- Ageing workforce having had a loyal and long serving staff team.
- Recruitment.
- Managing patient expectations.
- Resources.
- And maintaining a work/life balance.

Their strategy for responding to the challenges included:

- The appointment of a lead to review staff skills within the practice and identify where upskilling could take place.
- Skill development would lead to increased staff retention.
- A nurse had recently been recruited and training options had been scheduled in preparation for the future retirement of one of the nurses.
- Skill gaps would provide recruitment opportunities and offer career progression including the appointment of apprentices.

Governance arrangements

The practice had a governance framework in place that supported the delivery of the strategy and good quality care for its patients. 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 and the roles and responsibilities of other staff within the practice. Practice specific policies were implemented and were available to all staff. Staff confirmed they had easy access to all of these at any time.
- The practice had a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements to the services they provided. Learning and changes to practice was shared with other practices within the Clinical Commissioning Group (CCG) so that good practice and learning was disseminated widely.
- There were systems and procedures in place to ensure the safety of everyone at the practice.
- The practice recognised and provided services appropriate to their patient needs and demographics.
- Evidence of meetings demonstrated willingness for the practice to share information internally and within other forums. Particularly, the weekly journal club which had been extended to other practices locally.

Leadership and culture

During the inspection the GPs and the management team demonstrated that:

- They had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care.
- They were aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- They encouraged a culture of openness and honesty.
- Staff confirmed that the GPs and the practice manager were visible in the practice.
- There was a clear leadership structure in place and staff felt supported by the management team. Staff told us that they were always approachable and they could speak with any one of the team should they have any concerns or queries or concerns.

Are services well-led?

Outstanding

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

- Staff said there was a no blame culture which made it easier for them to raise issues.
- Staff told us that it was a lovely practice to work for and that everybody worked together well as a team to do their best for patients.
- Staff told us that GPs at the practice were caring and supportive and they went the extra mile for their patients.

There was evidence of the strong teamwork within the practice from all staff. The commitment to providing quality patient care was evident particularly in the passionate approach by all staff to patients and their job.

GPs had provided additional support in the community.

- The practice was an active member of the GP federation. The practice manager was the managing director of the federation and the head office was located at the practice. This was seen as a significant benefit for the practice and patients in resourcing funding opportunities for the practice, their patients and other members of the federation. An example was given to us of the search for a telephone system that would enable more effective communications with and between members of the federation.
- Additional services were provided including medical advisor for local tourist attractions and national competitions.

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

The practice encouraged and obtained feedback from patients in the delivery of the services they provided.

- Feedback had been gathered from patients through their Patient Participation Group (PPG) (known as Friends of Waterside Medical Centre) and through surveys and complaints received. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. There were 24 core group members of the PPG. Bi-monthly meetings were held, and the chairman of the PPG also sat on the CCG patient group to share information at a wider level.
- The practice also had a virtual PPG in place to ensure that all patient groups were represented in providing feedback. For example, there were four members under 45 years of age in the core PPG. The practice had seen real improvement in engagement through the creation of the virtual PPG, which recognised that young people found it difficult andoff-putting to attend physical meetings. The practice had a total of 152 members on the virtual PPG, 104 of whom were under 45 years of age and 58 of whom were under 25 years of age.
- The chair of the PPG told us that the group engaged and supported the charity work at the practice and the flu clinics.

We looked at the PPG annual report for 2015/2016 and saw many examples where the PPG had made suggestions for improvements which had been acted upon by the practice:

- They had requested fresh water was made available for patients to drink. A fresh water fountain had been installed in the reception area.
- Improved car park lighting; the lighting was upgraded to modern LED lighting
- Improved patient information leaflets; leaflets were developed and racks installed in the waiting area so that leaflets were clearly accessible.
- Text messaging service was implemented. This provided patients with appointment reminders and gave patients the option to cancel their appointments.
- Slides on the screen were simplified; size increased and the transition speed reduced following feedback from the PPG.
- Internal signage was improved with additional signs added to include braille signs.
- Music to the waiting area was changed as the previously used local radio advertising undertaker services was not welcomed. The practice had obtained appropriate licences for other background music to be played.
- The PPG had been involved in the various charity events held at the practice. Over the past five years the practice had held three summer fetes and annual flu clinic coffee mornings and raised over £7,200 for local charities.

We saw many examples where staff had been involved and encouraged to provide feedback to contribute to the development of the practice.

- Regular staff meetings took place.
- Staff surveys were completed so that every member of staff was able to give their views about the practice and make suggestions for improvements.
- Annual appraisals were completed for all staff.

Are services well-led?

Outstanding

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

Continuous learning and development

There was a strong focus on continuous learning and improvement at all levels within the practice.

- The practice had engaged with Age UK to assess and support all high risk patients aged 75 and over to identify and address clinical and social need. This involved proactive health reviews for patients with a view to identifying measures to help them to maintain good health.
- The practice had identified 739 patients who were taking in excess of eight medicines. They had engaged in a project in partnership with the South Warwickshire NHS Foundation Trust (SWFT). The project explored innovative and proactive use of a clinical pharmacist in primary care. The project focused on the frail elderly to reduce risk of Hospital Admissions Related to Medicines (HARMS) and reduce medicines waste. The project ran from February 2016 until the end of May 2016. The success of this project had encouraged the practice to employ the pharmacist for two days per week so that this work could continue. They planned to extend the service to include patients aged 75 years and over with long term conditions who had been discharged from hospital. Following the inspection the practice learned that they had been nominated for a Health Services Journal (HSJ) award for this project.
- The practice was a research ready practice. They routinely took part in primary care research in order to expand knowledge for their staff towards improved services for patients. Recent programmes had included the use of automated risk assessments for patients with Atrial Fibrillation (heart disease) to identify those who were at risk of a stroke; and the use of a medicine to prevent ulcers bleeding with trials due to end in 2017.
- The practice had engaged with the Healthy Homes project, funded by a grant from British Gas Energy Trust. Assessments of 739 patients who are 75 years and over were to be carried out to determine eligibility for funding support. The project had identified that fuel poverty and cold homes could exacerbate a range of health problems and estimates suggested that 10% of excess winter deaths were attributed to the coldest quarter of homes. The practice hoped that this project would improve patients' quality of life and reduce the impact of frailty on health.
- They had recently engaged in a pilot programme to run for 12 months aimed at designing an integrated frailty pathway to reduce hospital attendance and improve patient care. The pilot required staff training and involvement in redesigning the pathway for primary and secondary care, which was being undertaken by the practice manager.
- They had delivered training for local residents in emergency resuscitation procedures in conjunction with another agency and at the time of the inspection had seen over 1,000 residents trained. This had been developed further with the completion of a train the trainer programme which had enabled the practice to extend this training to other practice staff locally.