The Village Surgery

Quality Report

49 High Street
Wolstanton
Newcastle Under Lyme
ST5 0ET
Tel: 01782 626172
Website: www.thevillagesurgery.co.uk

Date of inspection visit: 4 December 2017
Date of publication: 08/01/2018

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. We previously inspected this practice on 26 January 2015 and rated it Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at The Village Surgery on 4 December 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice had systems to safeguard children and vulnerable adults from the risk of abuse and staff were aware of these.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- Staff worked with other health and social care professionals to deliver effective care and treatment.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it. Data from the national patient survey showed that 95% of patients described their experience of making an appointment as good.
- The management team were aware of the challenges the practice faced and had plans in place to address

Summary of findings

them. For example, they had implemented plans to reduce their antibiotic prescribing rate and also to increase the quality of care for patients with diabetes.

- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- Staff we spoke with were aware of the practice's vision to provide patients with high quality, safe, accessible care in a responsive and courteous manner. They were aware of their roles in achieving this. There were very positive relationships between staff and teams.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

The Village Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and an expert by experience.

Background to The Village Surgery

The Village Surgery is registered with the Care Quality Commission (CQC) as a partnership provider and is located in Wolstanton, North Staffordshire. It provides care and treatment to approximately 7,044 patients of all ages. The practice holds a General Medical Services (GMS) contract. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice delivers services from one location which we visited during our inspection:

- The Village Surgery, 49 High Street, Wolstanton, Newcastle Under Lyme, ST5 0ET

The practice area is one of low deprivation when compared with the national and local Clinical Commissioning Group (CCG) area. Demographically the practice has a patient age distribution comparable with the CCG and national averages. The percentage of patients with a long-standing health condition is 52% which is comparable with the local CCG average of 57% and national average of 53%.

The practice staffing comprises of:

- Two GP partners (one male and one female). The practice are in the process of adding an additional male GP partner.
- A GP Registrar
- Three practice nurses and a health care assistant.
- A practice manager and assistant practice manager.
- Nine members of administrative staff working a range of hours.

The Village Surgery is open between 8am and 6pm Monday to Friday except for Thursdays when it closes at 1pm. Appointments are from 8am to 11am every morning and 3pm to 5.30pm daily except for Thursday afternoon when the practice is closed. Telephone consultations are also available to suit the needs of the patient. Cover to patients in the out-of-hours period is provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

The practice offers a range of services for example, management of long term conditions such as diabetes, contraceptive advice, immunisations for children, travel vaccinations, minor operations and NHS checks. Further details can be found by accessing the practice's website at www.thevillagesurgery.co.uk

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had safety policies which were regularly reviewed and communicated to staff. Staff received safety information as part of their induction and refresher training.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed but staff were unable to locate the policy for safeguarding vulnerable adults on the day of our inspection. The practice amended the title of this policy on the day of our inspection to enable staff to locate it more readily. The safeguarding policies outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice's recruitment policy stated that explanations for gaps in employment history would be sought at the time of interview by the selection panel. However we saw there were unexplained gaps in employment history for a new member of staff. The practice accounted for these gaps on the day of our inspection.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. Clinical staff had received appropriate immunisations against health care associated infections. Some non-clinical staff had not received these immunisations. Risk assessments had not been completed to demonstrate how potential risks to staff and patients would be mitigated. The day after our inspection the practice sent us completed risk assessments to mitigate these risks and shared their updated hepatitis B policy with staff.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Reception staff had been trained to identify rapidly deteriorating patients and had received training in sepsis. A 'Think about Sepsis' poster was clearly displayed in the reception area for staff to refer to for guidance and support.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the practice had a

system in place for sharing information with the out of hours service for patients nearing the end of their life or if they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) plan in place.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The GPs did not routinely take emergency medicines on home visits. A risk assessment to demonstrate how they had arrived at this decision had been completed and identified actions the practice took to mitigate potential risks. For example, requests for home visits were triaged by the GP to determine if any specific emergency medicines were required. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current local and national guidance. The practice had audited antimicrobial prescribing. For example, audits of antibiotics used for the treatment of coughs or urinary tract infections had been completed. However, the GPs identified that to fully understand the effectiveness of their prescribing the duration of patients' symptoms needed to be considered. Repeat audits were planned to include this information.
- Patients' health was monitored to ensure medicines were being used safely and followed up appropriately. The practice audited their use of high risk medicines and involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. To ensure that patients and staff were protected from the risk of water borne infection a legionella risk assessment had been completed in response to a recommendation at our previous inspection.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Staff told us that the GPs and practice manager supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, a GP completed a referral for a patient with possible cancer using the urgent two week wait referral pathway. However, there was a delay in the referral being sent to the hospital. The practice reviewed its procedures to ensure there was a system in place to ensure urgent referrals had been received by the hospital.
- The practice shared their learning from relevant significant events externally with local stakeholders.
- The practice had systems in place to monitor the effectiveness of any changes made that had resulted from learning from a significant event.
- There was a system for receiving and acting on safety alerts such as Medicines and Healthcare products Regulatory Agency (MHRA) alerts. Safety alerts were a standard agenda item for clinical and practice meetings and the practice learned from them.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- The practice followed the National Institute for Health and Care Excellence (NICE) guidelines to ensure that patients' needs were fully assessed and care and treatment was delivered in line with national guidelines. This included their clinical needs and their mental and physical wellbeing.
- Data from electronic Prescribing Analysis and Costs (ePACT) for specific therapeutic medicines such as hypnotics (medicines used to aid sleep), antibacterial items and antibiotics was comparable with other practices. ePACT is a system which allows authorised users to electronically access prescription data. Clinical staff had received training in antimicrobial resistance to support their understanding and appropriate prescribing of antibiotics.
- Data from the clinical commissioning group (CCG) showed that the practice had been the fifth highest prescriber of antibiotics in the CCG for the number of antibacterial prescription items prescribed per specific therapeutic group. The practice had worked with the CCG medicines management team to audit and identify where changes could be made to their prescribing. The most up to date data available showed that the actions taken by the practice had started to impact on their prescribing rate. For example, they had moved to the sixth highest prescriber in the CCG and their number of antibacterial prescription items prescribed per specific therapeutic group of 1.2 was slightly higher than the CCG target of 1.16. However, the percentage of broad spectrum antibiotics prescribed by the practice was 1.15% which was below the CCG target of 4.1%. It is important that antibiotics are used sparingly to avoid medicine resistant bacteria developing. These results indicate that the practice was following national and local guidance.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used technology and equipment to improve treatment and to support patients' independence. For example, near patient monitoring of blood clotting levels and 'map of medicine' to facilitate referrals along accepted pathways of care.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs by the elderly care facilitator lead nurse. If they were housebound, this assessment was provided in their home.
- Older patients received a routine review of their medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice had offered 74 patients a health check and 49 of these checks had been carried out.
- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice offered self-management plans for patients with long term conditions such as diabetes or asthma.

Good

Are services effective?

(for example, treatment is effective)

- The Quality Outcome Framework (QOF) results for 2016/17 showed that care and treatment provided for patients with long term conditions, such as high blood pressure, asthma and chronic obstructive pulmonary disease, were in line with local and national averages. QOF is a system intended to improve the quality of general practice and reward good practice. However, results for patients with diabetes were lower:
- 68% of patients with diabetes, on the register, had a blood test that was within recognised limits to monitor how well controlled their blood glucose had been over the previous two to three months. This was below the Clinical Commissioning Group (CCG) average of 80% and the national average of 79%. However, their exception rate of 2% was lower than the CCG average of 10% and the national average of 12% meaning more patients had been included. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.
- 74% of patients with diabetes, on the register, had a blood pressure reading (measured in the preceding 12 months) that was within recognised limits. This was slightly lower than the CCG average of 80% and the national average of 78%. However, their exception reporting rate of 2% was lower than the CCG and national averages of 9%.
- 66% of patients with diabetes, on the register, had received cholesterol level testing (measured within the preceding 12 months) and it was within recognised limits. This was below the CCG average of 81% and the national average of 80%. However, their exception reporting rate of 6% was lower than the CCG average of 14% and national average of 13%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above. For example, rates for all the vaccines given to under two year olds were 99% and five year olds ranged from 96% to 99%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- There were alerts on childrens' records to inform clinicians if a child had a child protection in place.
- The practice used a picture pain assessment tool to help young children to describe their level of pain.

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

- The practice's uptake for the cervical screening programme was 81%. This was comparable with the CCG average of 82% and the national average of 81%. Their exception reporting rate of 3% was lower than the CCG average of 5% and the national average of 8%.
- The meningitis vaccine was available for eligible patients such as those attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including carers and those with a learning disability.
- One hundred per cent of patients registered with the practice and who had a learning disability had received an annual health review in 2016/17.
- The practice used an easy read pain assessment tool to help patients with a learning disability to describe their level of pain.

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

- 84% of patients diagnosed with dementia had a care plan in place that had been reviewed in a face-to-face review in the preceding 12 months. This was comparable with the CCG average of 85% and the national average of 84%.
- 92% of patients with a diagnosed mental health disorder had a comprehensive, agreed care plan

Good

Are services effective?

(for example, treatment is effective)

documented in their record, in the preceding 12 months. This was comparable with the CCG average of 91% and the national average of 90%. Their exception reporting rate of 2% was lower than the CCG and national averages of 13%.

- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 92% of patients with a diagnosed mental health disorder had their alcohol consumption recorded in their notes in the preceding 12 months. This was comparable with the CCG average of 92% and national average of 91%. However, their exception reporting rate of 2% was lower than the CCG average of 9% and national average of 10%.
- The practice proactively followed up patients who had been admitted to A&E due to self-harm and patients experiencing poor mental health who failed to attend for GP appointments.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, the practice carried out minor surgery and had completed audits of infection rates in patients following surgery. We saw that although the infection rate had fallen from 1% to 0.66% a GP had taken further advice from an allied health professional to decrease the rate further. The practice planned to repeat the audit to ensure ongoing improvement in their post-surgery infection rates. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the electronic frailty index (eFI) which helped to identify and predict adverse outcomes for frail, older patients and NHS health checks for working age patients.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The most recent published results for 2016/17 showed the practice had achieved 94% of the total number of points available compared with the CCG average of 97% and national average of 96%. Their overall clinical exception reporting rate of 3% was below the CCG and national averages of 10%. We saw that some QOF indicators for patients with diabetes were lower than the CCG and national average. The GPs were aware of this and we explored this with them during our inspection. They told us this was in part due to the low exception reporting rates for this group of patients and described the changes they had made in reviewing patients with diabetes. For example, to optimise medicine prescribing patients were seen by a GP rather than the practice nurse if their diabetes was not adequately controlled. The GPs we spoke with felt confident that the changes they had made would improve the outcomes for these patients.

Data collated by the CCG showed a downward trend in the number of practice patient attendances to A&E and unplanned hospital admissions. For example, the rate of A&E attendances for all age groups over a rolling 12 month period had fallen from 263 to 239 per 1,000 patients and unplanned hospital admission rates had fallen from 91 to 74 per 1,000 patients.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. The management team described the action they had taken to address the behaviour of a temporary member of staff following concerns raised by others.

Coordinating care and treatment

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

- We saw records that showed all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The practice showed us testimonials from five allied health professionals, for

Good

Are services effective?

(for example, treatment is effective)

example a community matron and manager of a care home, which demonstrated the practice worked collaboratively and responsively with them to provide patient centred care.

- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, the practice produced patient newsletters. We saw that they used these letters to promote awareness and understanding of long term conditions such as diabetes.
- The practice supported national priorities and initiatives to improve the population's health. For example, they provided weight management advice and sign posted patients requiring smoking cessation support to appropriate services.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. They supported patients to make decisions and involved family members or patient advocates to support patients who lacked capacity regarding elements of their care.
- The practice had written consent forms for surgical procedures which included appropriate advice.

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. For example, the practice had referred frail patients at risk of social isolation to the voluntary and community sector hub. This provided a befriending service and/or transport to social groups.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. A notice to this effect was on display in the reception area. Confidentiality slips were also available for patients to discreetly hand to a receptionist to request a private conversation.
- Prior to our inspection we spoke with a member of the patient participation group (PPG). They told us that the practice respected the views and suggestions of the PPG. They also told us that the best attribute of the practice was that they cared about their patients and gave examples to demonstrate this.
- We received 61patient Care Quality Commission comment cards, 55 from patients and six from staff members. All were extremely positive about the care and treatment experienced. This was in line with the results of the NHS Friends and Family Test and most of the 16 patients we interviewed on the day of our inspection. Patients told us staff were caring, respectful, friendly, helpful, listened and gave them enough time.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and fifty surveys were sent out and 101 were returned. This represented approximately 1.4% of the practice patient population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared with the CCG average of 89% and the national average of 86%.
- 98% of patients said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 87% and the national average of 86%.
- 98% of patients said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 98% of patients said they found the receptionists at the practice helpful compared with the CCG and national averages of 87%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. We saw a notice in the reception area in multiple languages informing patients this service was available. One of the GPs spoke several different languages.

Good

Are services caring?

- Staff communicated with patients in a way that they could understand, for example, communication aids such as a hearing loop were available. The reception desk was at the optimal height for wheelchair users to hold face to face conversations with reception staff.
- Staff helped patients and their carers to find further information and access community and advocacy services. They helped them to ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice used new patient registration checks and GP consultations to identify any new carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 161 patients as carers (2.3% of the practice list). Carers were offered health checks and flu immunisations to support them to remain fit and well.

The practice had recently started to send letters of condolence to patients who they were aware of who had experienced recent bereavement. We saw an example of a letter sent however it did not include an offer of support or guidance to bereavement support services. The practice updated their condolence letter on the day after our inspection.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 83% and the national average of 82%.
- 96% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG and national averages of 90%.
- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. Staff who chaperoned understood their responsibilities of maintaining a patient's dignity during an intimate examination.
- The practice complied with the Data Protection Act 1998 and all staff had signed confidentiality agreements.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, online services such as repeat prescription requests, advanced booking of appointments, and near patient blood testing for patients prescribed warfarin (a medicine that stops blood clotting).
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services such as the Integrated Local Care Team (ILCT), a team that included health and social care professionals.

Older people:

- All patients had a named GP who supported them in the setting they lived, whether it was at home or in a care home.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice worked with the voluntary sector, such as Age UK and the Voluntary Care Sector Hub, to support older patients and those who may be socially isolated.
- The practice offered an onsite phlebotomy service for older patients so they did not have to travel far for blood testing.
- The practice used the frailty index to identify health risks to this population group.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the ILCT to discuss and manage the needs of patients with complex medical issues.
- The practice provided in-house electrocardiology monitoring, spirometry and lifestyle advice for patients with long term conditions.

Families, children and young people:

- We found there were systems 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 (A&E) attendances. The health visitor attended the practice weekly and discussed any children of concern if needed.
- Twice weekly antenatal clinics were held with the midwife at the practice.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- Appointments were available outside of school hours.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, early morning and late afternoon appointments and telephone consultations.
- The practice offered online services to support repeat prescription requests and booking of appointments. A text messaging service was also available to remind patients of their appointment times.
- Patients aged over 40 years were offered NHS Health Checks to identify those at risk of cardiovascular disease and other chronic conditions.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held a register of patients living in vulnerable circumstances including children with a child protection plan in place and those with a learning disability.
- The practice supported and signposted vulnerable patients, such as carers or those socially isolated, to access voluntary support services such as the voluntary and community sector hub.
- Reception staff had received training to support them to recognise vulnerable adults.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients experiencing poor mental health who failed to attend practice appointments or attended A&E were proactively followed up by the practice.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was significantly higher than local and national averages. Two hundred and fifty surveys were sent out and 101 were returned. This represented approximately 1.4% of the practice patient population. These results were supported by our observations on the day of our inspection and completed comment cards. Patients we spoke with told us there was flexibility in the appointments offered and they were easy to make.

- 94% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 89% of patients said they could get through easily to the practice by phone compared with the CCG average of 69% and the national average of 71%.
- 88% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 86% and the national average of 84%.
- 91% of patients said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 95% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 85% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 64% and the national average of 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do.
- The complaints policy and procedures were in line with recognised guidance. One written complaint and 11 verbal complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- There were accessible complaints leaflets for patients to refer to for advice regarding who they could complain to. We reviewed two response letters sent to patients and saw that one of them did not inform patients of their right to complain to the Parliamentary and Health Service Ombudsman (PHSO). Following our inspection, the practice amended their complaints' procedures to ensure that patients who complained verbally or in writing were informed of their right to complain to the PHSO.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For

Good

Are services responsive to people's needs?

(for example, to feedback?)

example, a patient was unhappy because the practice had given a local pharmacist their telephone number to contact them in regards to an issue with their prescription. The practice changed its policies and procedures to ensure that patient details were not provided to other organisations but the practice contacted patients directly.

- The practice proactively monitored and acted on complaints posted on the national website, NHS Choices.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice was aware that their prescribing of antibiotics was the fifth highest in the Clinical Commissioning Group (CCG) and were working closely with the medicines management team to reduce it.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- Two GPs at the practice held external leadership roles within the CCG. For example, clinical director for mental health and specialist groups and a clinical associate. We saw that the knowledge and experiences they gained from these roles supported their leadership skills.

Vision and strategy

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

- There was a clear vision and set of values. The practice had developed a mission statement to support their vision and values: 'To provide our patientswith high quality, safe, accessible care in a responsive and courteous manner.' The practice had a strategy and a supporting five year business plan to achieve priorities.
- The practice vision and mission statement were displayed throughout the practice. Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. There was a low turnover of staff at the practice and staff told us they felt privileged to work at the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with their vision and values. The management team described the action they had taken to address the behaviour of a temporary member of staff following concerns raised by others.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, a deceased patient was sent an invite for an immunisation. This caused distress for the family. To prevent this from occurring again the practice amended their systems to alert staff of deceased patients. We saw that the practice had a system in place to monitor the effectiveness of changes made.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. For example, we saw how the practice manager had been supported to progress from a receptionist to their current role. All staff had received regular annual appraisals in the last year and career development when needed. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. A practice nurse told us the practice was planning to support her to complete appropriate prescribing training.

Are services well-led?

Good

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

- There was a strong emphasis on the safety and well-being of all staff. One member of staff spoke passionately about the support she had received from the practice in her role as carer for a family member.
- The practice actively promoted equality and diversity and gave examples of when they had supported a patient to ensure their equality was maintained. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were very positive relationships between staff and teams. We saw that leaders were highly respectful of the skills and knowledge each member of the leadership team provided.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear of their roles and accountabilities in relation to safeguarding children and vulnerable adults and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. We saw that policies were regularly reviewed, updated and shared with staff.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. The practice's five year business plan supported monitoring of these risks.
- Practice leaders had oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts, incidents, and complaints. There were effective systems in place for reviewing and disseminating learning from these to relevant staff and monitoring of the actions taken.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence action had been taken to change practice and improve quality.
- The practice had plans in place and had trained staff for major incidents. There was a business continuity plan in place to support unplanned disruptions to the service.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. For example, the practice worked with the CCG to monitor patient attendance levels to A&E. To prevent inappropriate attendance to A&E an A&E manager had been identified within the practice, a practice nurse provided support to older, frail patients at home and GPs carried out proactive assessments. Performance information was shared with patients through the practice's newsletter.
- Quality and sustainability were discussed in regular clinical and staff meetings where all staff had sufficient access to information.
- The practice used performance information which was reported on and monitored.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, recent data from the local clinical commissioning group (CCG) showed the practice's prescribing for the number of antibacterial prescription items prescribed per specific therapeutic group was above the CCG target. Through collaborative working with the CCG medicine's management team and audits of antibiotic prescribing, the practice were trying to reduce their prescribing rate.
- The practice used information technology systems to monitor and improve the quality of care. For example, map of medicine to facilitate referrals along accepted pathways of care.

Are services well-led?

Good

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

- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- There was an active patient participation group (PPG). Prior to our inspection we spoke with a member of the PPG. They told us the practice engaged positively with the PPG and listened to their concerns and suggestions. For example, the practice had supported the PPG to implement new strategies for promoting the work of the PPG and as a result new members had joined the group.
- The practice engaged with patients by sharing information about their service through their newsletter.
- The service was transparent, collaborative and shared learning from near misses or incidents with external stakeholders when appropriate.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement within the practice. For example, the role of an elderly care facilitator was carried out by a practice nurse to provide additional support to older, frail patients in their home. To improve information sharing between primary and secondary care settings the practice were planning to develop frailty passports for when this group of patient were admitted to hospital or A&E.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements in the practice.