

Hartshill Medical Centre

Quality Report

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

Ratings

Overall rating for this service	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

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. We previously inspected this practice on 24 November 2014 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 at Hartshill Medical Centre on 28 November 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. However, a risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury had not been completed.
- The practice had clear systems to keep patients safe and safeguarded from the risk of abuse.
- The practice had developed effective ways of reducing patient A&E attendance. All patients that attended A&E were reviewed at a weekly clinical meeting.
- 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 involved and treated patients with compassion, kindness, dignity and respect.

Summary of findings

- The practice had signed up to the local authority's safer places scheme to work as part of a network of organisations to provide assistance and support to vulnerable people over 14 years if they felt anxious or scared whilst out in the community.
- The practice had responded to the issues patients experienced when trying to access appointments by recruiting an additional GP partner and planned to purchase a new telephone system.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Two of the GP partners were educational tutors at the local university. We saw that the knowledge and experiences they gained from these roles were embedded in the practice's culture of continuous improvement.

There was one area of outstanding practice:

- The practice provided two hours a week of dedicated appointments for the A&E department to redirect patients to the practice if they attended A&E

inappropriately. Data for 2015/16 and 2016/17 showed a fall from 14.7% to 11.9% of inappropriate A&E attendances for patients registered with the practice.

The areas where the provider **should** make improvements are:

- Update their recruitment policy to include reference to accounting for gaps in employment history and checking that professional registrations for clinical staff are in date.
- Complete a risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury.
- Continue to seek out ways to improve the identification of carers registered with the practice.
- Review the Care Quality Commission (Registration) Regulations 2009 to support their understanding of incidents that are notifiable to the Care Quality Commission.

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

Summary of findings

Areas for improvement

Action the service **SHOULD** take to improve

- Update their recruitment policy to include reference to accounting for gaps in employment history and checking that professional registrations for clinical staff are in date.
- Complete a risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury.
- Continue to seek out ways to improve the identification of carers registered with the practice.
- Review the Care Quality Commission (Registration) Regulations 2009 to support their understanding of incidents that are notifiable to the Care Quality Commission.

Outstanding practice

- The practice provided two hours a week of dedicated appointments for the A&E department to redirect patients to the practice if they attended A&E inappropriately. Data for 2015/16 and 2016/17 showed a fall from 14.7% to 11.9% of inappropriate A&E attendances for patients registered with the practice.

Hartshill Medical Centre

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 Hartshill Medical Centre

Hartshill Medical Centre is registered with the Care Quality Commission (CQC) as a partnership provider and is located in Hartshill, Stoke-on-Trent. It provides care and treatment to approximately 7,074 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:

- Hartshill Medical Centre, Ashwell Road, Hartshill, Stoke On Trent, ST4 6AT

The practice area is one of average 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 55% which is

comparable with the local CCG average of 57% and national average of 53%. The practice is a training practice for GP registrars and undergraduate medical students from a nearby university.

The practice staffing comprises:

- Five GP partners (four male and one female).
- A GP Registrar (male).
- Three practice nurses.
- A practice manager.
- Eight members of administrative staff working a range of hours.
- Three cleaners.

Hartshill Medical Centre is open between 8am and 6pm Monday to Friday except for Thursdays when it closes at 1pm. Extended opening hours are offered from 6pm to 8pm on Monday. Appointments are from 8.10am to 11.30am every morning and 2pm to 5.30pm daily except for Thursday afternoon when the practice is closed. Pre-bookable appointments can be booked up to two weeks in advance or four weeks in advance when booked on line. Urgent on the day appointments are available for those that need them. GP telephone consultations are also available for patients who are unable to attend the practice within normal opening hours. During the out-of-hours period services are 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, immunisations for children, travel vaccinations, minor operations (including male sterilisation) and child development checks. Further details can be found by accessing the practice's website at www.hartshillsurgery.co.uk

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 for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from the risk of abuse. Policies were regularly reviewed and were accessible to all staff. They 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). However, the practice's recruitment policy did not include accounting for gaps in employment history or checking that professional registrations for clinical staff were in date.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. At our previous inspection we found that receptionists that chaperoned had not received a DBS check. At this inspection we saw that DBS checks had been done and staff who acted as chaperones were trained for the role.
- There was an effective system to manage infection prevention and control. An infection control audit had been completed and an action plan developed and action taken to address the issues that were identified.

- 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. The practice had recently recruited an additional GP partner and were in the process of recruiting an additional practice nurse to address patient concerns about access to appointments.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Non-clinical staff had not received training in basic life support for over three years but plans to provide this training in January 2018 had been made. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Receptionists were aware of severe symptoms that might be reported by patients and had protocols detailing how to respond. For example, chest pain, profuse bleeding and stroke. However, protocols for sepsis were not in place.
- 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 detailed, appropriate and 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.

Are services safe?

- We reviewed two referral letters and saw that they included all of the necessary information. Reception staff were aware of their role in ensuring urgent referrals were sent promptly and had systems in place to monitor they had been received by the hospital.

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 such as oxygen, and emergency medicines and equipment minimised risks to patients. The practice had completed a risk assessment to determine the emergency medicines they held at the practice and those the GP took out on home visits. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed or 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. There was evidence that action taken supported good antimicrobial stewardship. For example, data from the local clinical commissioning group (CCG) showed a continuing downward trend in the number of antibacterial prescription items prescribed per specific therapeutic group. Latest figures showed the practice rate of 0.96 was below the CCG target of 1.16. It is important that antibiotics are used sparingly to avoid medicine resistant bacteria developing so this indicates that the practice was following national and local guidance.
- 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 for example, fire, lone working and health and safety. However, we saw that the practice had a mercury blood pressure monitoring device. Mercury spillage kits were available for use in the event of a mercury spillage. A risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury had not been completed.
- 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. Leaders and managers supported them when they did so.
- There were effective 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, the practice's information technology systems had been interrupted for a day following a cyber-attack. This meant that the practice did not have access to the time of patients' appointments. The practice demonstrated learning by introducing secure systems to back up the forthcoming weeks' appointments.
- There was a system for receiving and acting on safety alerts. Safety alerts were a standard agenda item for clinical and practice meetings. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Data from electronic Prescribing Analysis and Costs (ePACT) for specific therapeutic medicines for antibacterial items and antibiotics was comparable with other practices. ePACT is a system which allows authorised users to access prescription data. The most recent data from the local clinical commissioning group (CCG) showed a continuing downward trend in the percentage of broad spectrum antibiotics prescribed by the practice. We saw that the practice rate of 2.6% was below the CCG target of 4.1%.
- ePACT data showed that the average daily quantity of prescribed Hypnotics (medicines used to aid sleep) of 0.33 was lower than the Clinical Commissioning Group (CCG) average of 1.14 and the national average of 0.98.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used technology to support patients to access their service more readily. For example, the practice offered an online service for patients to request repeat prescriptions and to pre-book appointments. They also used a text messaging service to remind patients of their appointment times. To improve access to their service for patients living in nursing homes, the practice was participating in a trial using Skype consultations. Staff from the nursing home spoke positively about the impact and effectiveness of this service.
- 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. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services. Over a six month period the practice had carried out 107 of these checks.
- The practice followed up older patients that attended A&E or were discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The patient participation group (PPG) had worked closely with the practice, Age UK and Beat the Cold to provide an awareness morning at the practice. The event aimed to promote the uptake of the flu vaccine and to support older and vulnerable patients to stay warm throughout the winter.

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. For example, a GP partner had completed the Warwick diploma in diabetes care.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results for 2016/17 showed that 84% of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of asthma. This was higher than the CCG average of 78% and the national average of 76%. Their exception reporting rate of 3% was lower than the CCG average of 6% and national average of 8%. Exception reporting is the

Are services effective?

(for example, treatment is effective)

removal of patients from QOF calculations where, for example, patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

- 95% of patients with chronic obstructive pulmonary disease had received a review including an assessment of breathlessness in the preceding 12 months. This was comparable with the CCG average of 91% and national average of 90%.
- 97% of patients with a heart condition that causes an irregular heart rate and were at a moderate to high risk of stroke were treated with anti-coagulation therapy. This was higher than the CCG average of 90% and the national average of 88%.
- 83% 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 comparable with the CCG average of 80% and the national average of 78%.
- 92% of patients with diabetes, on the register, last measured total cholesterol (measured within the preceding 12 months) was within recognised limits. This was higher than the CCG average of 83% and the national average of 80%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Vaccine rates given to under two year olds ranged from 97% to 100% and five year olds uptake was 98%. This was above the national expected coverage of vaccinations of 90%. Practice nurses who were responsible for administering immunisations had received specific training and updates.
- The practice held regular meetings with the health visitor to discuss children at risk or families in need of additional support.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for the cervical screening programme was 85%. This was comparable with the CCG average of 79% and the national average of 81%. Their exception reporting rate of 4% was lower than the CCG average of 6% and the national average of 7%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before 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.
- The practice offered long acting reversible contraception and vasectomies.

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. There was a system in place to review 'do not attempt cardiopulmonary resuscitation' (DNACPR) plans.
- The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability.
- To support patients with a learning disability to express how they felt and understand the information provided to them easy read picture cards and leaflets were available in the practice.
- Vulnerable patients that attended A&E or the out of hours service were reviewed at weekly clinician meetings and a follow up appointment offered if needed.
- The practice offered annual health assessments for carers to ensure that their health needs were met.

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

- 92% 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 higher than

Are services effective?

(for example, treatment is effective)

the CCG average of 83% and the national average of 84%. However, their exception rate of 11% was slightly higher than the CCG average of 6% and the national average of 7%.

- 91% of patients with a diagnosed mental health disorder had a comprehensive, agreed care plan documented in their record, in the preceding 12 months. This was comparable with the CCG average of 89% and the national average of 90%. However, their exception reporting rate of 28% was significantly higher than the CCG average of 10% and the national average of 13%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 97% 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 21% was significantly higher than the CCG average of 7% and national average of 10%.
- There was a system in place to follow up or review patients experiencing poor mental health who attended A&E.
- Patients newly diagnosed with depression were followed up within four weeks. Patients at risk of self-harm were provided with reduced prescriptions and alerts added to their records. When this group of patients failed to attend appointments a GP reviewed their notes to assess their risk.

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 had carried out an audit of patients prescribed a medicine for the treatment of urinary frequency and incontinence. The first audit demonstrated that none of these patients had had their blood pressure monitored in line with a recent alert. All of these patients were invited for a review of their blood pressure and the practice implemented a six monthly recall system to ensure ongoing monitoring of this group of patients.

Where appropriate, clinicians took part in local and national quality improvement initiatives. For example,

assessing patient frailty through the use of a recognised frailty tool, shared care arrangements for patients on high risk medicines and the hospital admissions avoidance facilitator scheme.

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 100% of the total number of points available compared with the CCG average of 95% and national average of 96%. Their overall clinical exception reporting rate was 7% which was comparable with the CCG average of 9% and the national rate of 10%.

We saw that the exception rates for a number of clinical domains for patients experiencing poor mental health were significantly higher than the CCG and national average. We explored this with the GP partners during our inspection. The GPs clearly described the rationale for exception reporting these patients and documented the reason for exceptioning each patient in their records.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included 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 on going support. This included an induction process, appraisals, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

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 appropriate staff, including those in different teams, services and organisations,

Are services effective?

(for example, treatment is effective)

were involved in assessing, planning and delivering care and treatment. This involved close working with the Integrated Local Care Team (ILCT), a team that included health and social care professionals.

- 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.
- Staff from three local care homes told us they had a positive working relationship with staff at the practice and the GPs visited promptly when requested or made alternative arrangements for patients to be seen.
- The practice had identified a higher than average attendance of their patients at A&E because the practice was situated close to the A&E department. To reduce the number of inappropriate A&E attendances the practice reviewed all of their patients who attended A&E on a weekly basis. The practice provided two hours a week of dedicated appointments for the A&E department to redirect patients back to the practice if they inappropriately attended. Data for 2015/16 and 2016/17 showed a fall from 14.7% to 11.9% of inappropriate A&E attendances.

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.

- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway was 55% which was comparable with the CCG average of 57% and the national average of 50%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, they provided smoking cessation clinics and weight management advice.

Consent to care and treatment

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

- Clinicians had received training in the mental capacity act and the deprivation of liberty safeguards. They understood the requirements of this legislation and guidance when considering consent and decision making.
- Where appropriate, clinicians assessed and recorded a patient's mental capacity to make a decision. 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 monitored the process for seeking consent appropriately.
- The practice had written consent forms for surgical procedures which included appropriate advice.

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, patients of no fixed abode were supported to register with the practice and to use the practice address for correspondence relevant to their health. Patients from ethnic minorities were provided with details of the Asist advocacy service when required.
- 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.
- All of the 13 patient Care Quality Commission comment cards we received were positive about the service experienced by patients. Patients told us that staff were caring, friendly, approachable and gave them enough time. This was in line with comments received from a member of the patient participation group (PPG) who we spoke with prior to our inspection, the results of the NHS Friends and Family Test and patient comment feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and thirty surveys were sent out and 108 were returned. This represented approximately 1.6% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 97% of patients who responded said the GP was good at listening to them. This was above the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 87% of patients who responded said the GP gave them enough time which was comparable with the CCG and national averages of 86%.

- 100% of patients who responded said they had confidence and trust in the last GP they saw. This was above the CCG and national averages of 95%.
- 96% of patients who responded said the last GP they spoke to was good at treating them with care and concern. This was above the CCG average of 85% and the national average of 86%.
- 97% of patients who responded said the nurse was good at listening to them. This was above the CCG average of 92% and the national average of 91%.
- 97% of patients who responded said the nurse gave them enough time. This was above the CCG and national averages of 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw. This was comparable with the CCG and national averages of 97%.
- 97% of patients who responded said the last nurse they spoke to was good at treating them with care and concern. This was above the CCG and national averages of 91%.
- 97% of patients who responded said they found the receptionists at the practice helpful. This was above the CCG average of 86% and the national average 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.
- Staff communicated with patients in a way that they could understand. For example, easy read picture cards and leaflets were available for patients with a learning disability to support them to express how they felt and understand the information provided to them.
- Staff helped patients and their carers to find further information and access community and advocacy services for example, through collaborative working with the local residents' association and the carer's hub.

Are services caring?

- We spoke with staff from three local care homes that the practice worked with. They told us the GPs took time to speak with patients and families, especially around end of life care and 'do not attempt cardiopulmonary resuscitation' decisions. They told us that the GPs were very caring and responsive to the needs of patients.

The practice had identified patients who were carers through new patient questionnaires, health reviews and liaison with the PPG. They encouraged patients to inform the practice if they were a carer through posters and social media. The practice had identified 58 patients as carers (0.8% of the practice list).

- The practice supported carers by offering carers a health assessment and flu immunisations. The practice was hosting sessions with the carer's hub the week after our inspection to raise awareness about the support available for carers outside of the practice.
- The practice sent condolence letters to support recently bereaved patients and provided bereavement visits if required.

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 above local and national averages:

- 95% of patients who responded said the last GP they saw was good at explaining tests and treatments. This was above the CCG average of 87% and the national average of 86%.
- 94% of patients who responded said the last GP they saw was good at involving them in decisions about their care. This was above the CCG and national averages of 82%.
- 95% of patients who responded said the last nurse they saw was good at explaining tests and treatments This was above the CCG average of 91% and the national average of 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care. This was above the CCG average of 87% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff we spoke with recognised the importance of maintaining patients' privacy and dignity.
- The practice complied with the Data Protection Act 1998 and all staff had signed confidentiality agreements.
- A member of the PPG told us how the practice had responded to their request to improve confidentiality at the reception desk by displaying signs informing patients to stand away from the desk.

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, extended opening hours on Monday, skype consultations and online services such as repeat prescription requests.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered. We saw there were chairs of varying heights in the waiting room and a wheelchair available for patients with impaired mobility.
- 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. There was an effective system in place to review, and follow up as needed, all patients that attended the A&E department.

Older people:

- All patients aged over 75 years had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home.
- The practice aimed to offer follow up appointments with the same GP to ensure continuity of care.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice provided a service to three local care homes and visited patients on request. The practice nurses provided immunisations, for example for the flu, for older patients living in care homes.

- The practice had worked with the patient participation group, Age UK and Beat the Cold to raise awareness amongst older patients about the support available to them.
- The practice used a frailty tool to identify older patients who needed regular reviews, increased monitoring and support from different services.

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. Home visits were provided if a patient was housebound.
- The practice held regular meetings with the local district nursing team and Integrated Local Care Team (ILCT), a team that included health and social care professionals, to discuss and manage the needs of patients with complex medical issues.
- Patients with long term conditions were offered double appointments to meet their needs.
- There were effective weekly systems to identify and follow up patients with long term conditions who attended or had a high number of accident and emergency (A&E) attendances.
- The practice provided in-house electrocardiology monitoring, spirometry, ambulatory and home blood pressure monitoring for patients with long term conditions.

Families, children and young people:

- There were effective systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who attended or had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- 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 also available outside of regular school hours.
- The practice offered pre-natal counselling for women with long term medical conditions if required and

Are services responsive to people's needs?

(for example, to feedback?)

ante-natal care in conjunction with community midwifery services. They also provided post-natal care including early discussions about family planning to reduce the risk of unplanned pregnancies.

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, extended opening hours before 9am and on Monday evenings.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice provided online services for repeat prescription requests, advanced booking of appointments and advice services for common ailments.
- The practice provided sexual health and contraceptive services including implants, coils and vasectomies for men.
- 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:

- The practice held a register of patients living in vulnerable circumstances including homeless people, carers and those with a learning disability.
- The practice supported patients of no fixed abode to register with the practice and to use the practice address for correspondence relevant to their health.
- The practice had signed up to the local authority's safer places scheme to work as part of a network of organisations to provide assistance and support to vulnerable people over 14 years of age if they feel anxious or scared whilst out in the community. Training for all staff to deliver this service was planned for February 2018.
- The practice worked with the district nursing team to support patients near the end of their life.

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 with dementia were offered an annual review in their birthday month.
- Patients experiencing poor mental health who attended A&E were discussed at weekly clinical meetings.

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.

Prior to our inspection we spoke with a member of the patient participation group (PPG). They told us the PPG had recently carried out a survey within the practice regarding patient satisfaction with the appointment system. The results were being analysed at the time of our inspection. The PPG also worked closely with the practice to monitor and improve the number of patients who failed to attend their appointment. Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable with local and national averages. This was supported by observations on the day of our inspection and completed CQC comment cards. Two hundred and thirty surveys were sent out and 108 were returned. This represented approximately 1.6% of the practice population. Data showed:

- 77% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 85% of patients who responded 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 83% and the national average of 84%.
- 79% of patients who responded said their last appointment was convenient compared with the CCG and national averages of 81%.

Are services responsive to people's needs? (for example, to feedback?)

- 69% of patients who responded described their experience of making an appointment as good compared with the CCG and national averages of 73%.
- 53% of patients who responded said they do not normally have to wait too long to be seen compared with the CCG and national averages of 58%.

However, only 55% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 67% and the national average of 71%. The practice informed us that they had increased the number of hours provided by receptionists and were purchasing a new telephone system to respond to this need.

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. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Eight complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- 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 example, the practice had identified there was a trend in complaints about access to appointments. In response to this, they had worked with the patient participation group (PPG) to understand the issues and held annual appointment review meetings to explore ways of improving the service.

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 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, to address concerns regarding access to appointments the practice had recruited an additional GP partner and were purchasing a new telephone system.
- 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. Clinical staff held lead roles within the practice for example, there was a clinical lead for dementia, information governance, prescribing and end of life care.

Vision and strategy

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

- The practice had a clear vision which was to provide Excellent Care - Excellent Training – Excellent Service. The practice also had a clear set of values, strategy and supporting business plans to achieve their priorities.
- Most 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.

- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. 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 need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. 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, areas they held lead roles in and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- The practice had trained and appointed two GPs to act as 'Freedom to Speak up' guardians to support staff working in primary care to raise any concerns at the earliest opportunity.

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. Each clinician held lead roles in dedicated areas. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Are services well-led?

Good 

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

- 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.

Managing risks, issues and performance

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

- There was a system in place to identify, understand, monitor and address current and future risks including risks to patient safety. However, a risk assessment to reflect guidance from The Control of Substances Hazardous to Health Regulations 2002 (COSHH) in relation to the storage or spillage of mercury had not been completed.
- Practice leaders had oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts, incidents, and complaints.
- The practice had developed an audit plan based on The National Institute for Health and Care Excellence (NICE) guidelines and the learning needs of staff. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to 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. Performance information was combined with the views of patients.
- The practice worked with the local clinical commissioning group (CCG) to monitor their performance through the quality information framework (QIF). Performance information was reported, monitored and there were plans to address any identified weaknesses. For example, the practice had reviewed their system of recall for patients in need of repeat blood pressure monitoring following a review of the QIF data for this group of patients.

- The practice used information technology systems to monitor and improve the quality of care. For example, OptimiseRx for patient medication reviews and a system to manage investigation results.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- When reviewing the practice's significant event log we identified an incident that had occurred at the practice which required the practice to submit a statutory notification to the Care Quality Commission (CQC). However, this had not been done.

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.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice carried out vasectomies at the practice. It had completed a patient satisfaction survey to determine if any improvements could be made to the delivery of this service. As a result of the feedback, the day the service was provided was changed to a Friday. This meant that patients could convalesce over the weekend without the need to take time off from work.
- There was an active patient participation group (PPG) and virtual PPG that worked closely with the practice to seek out patients views and make improvements to the practice. The practice also engaged with patients by sharing information about their service with the local residents association and through their newsletter.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice.
- The practice was a training practice for undergraduate and postgraduate trainees, two of the GP partners were

Are services well-led?

Good 

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

educational tutors at the local university. We saw that the knowledge and experiences they gained from these roles were embedded in the practice's culture of continuous improvement.

- Staff knew about improvement methods and had the skills to use them.

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- To improve access to their service for patients living in nursing homes, the practice was participating in a trial using Skype consultations.