Mirfield Health Centre

Quality Report

Doctor Lane,
Mirfield
WF14 8DY
Tel: 01924 483440
Website: www.mirfield-healthcentre.co.uk

Date of inspection visit: 14 February 2018
Date of publication: 09/03/2018

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. (The practice was previously inspected on 7 July 2016. On that occasion the practice received a rating of Good overall, with a rating of Outstanding for providing effective services).

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 Mirfield Health Centre on 14 February 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear governance policies and protocols which were accessible to all staff.
- There were well developed systems to identify and manage risk within the practice. Processes for recognising, reporting and learning from incidents were embedded.
- The practice routinely reviewed the effectiveness and appropriateness of the care provided. Care and treatment was delivered in line with current evidence based guidance. The practice benchmarked performance against other practices in the locality.
- The practice had responded to patient survey results relating to delays in accessing appointments. They had made improvements and changes to their systems; and provided evidence which showed that abandoned calls and call wait times had been significantly reduced; the number of available appointments had significantly increased and waiting times to be seen had reduced in the period between January 2017 and January 2018.
- We observed staff treating patients with kindness, compassion and good humour. Patients we spoke with confirmed this impression.

Summary of findings

- Staff were encouraged and supported to develop within their role. Staff at all levels were able to access role development opportunities.
- The practice engaged in a positive way with the local community. Sponsorship was provided for a local girls' football team, there was reciprocal engagement with the local primary school, and outreach support was provided to a nearby hostel for homeless people.

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

- Improve systems for collating and recording informal verbal complaints and compliments.
- Improve record keeping associated with the cleaning of equipment.
- Continue to monitor, review and take steps to improve patient satisfaction in accessing appointments and receiving care.
- Review their arrangements for the identification of carers to assure themselves that they are identifying them effectively, and are able to offer them the appropriate support.

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

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people	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

Mirfield Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.**The team included a GP specialist adviser and a second CQC inspector.

Background to Mirfield Health Centre

Mirfield Health Centre is situated at Doctor Lane, Mirfield WF14 8DU. There are currently 17,210 patients registered on the practice list. The practice provides General Medical Services (GMS) under a locally agreed contract with NHS England.

The Public Health National General Practice Profile shows that around 2% of the patient population are of Asian origin, and approximately 2% are of mixed ethnicity, with the remainder being of predominantly white British origin.The level of deprivation within the practice population group is rated as eight, on a scale of one to ten. Level one represents the highest level of deprivation, and level ten the lowest.

The age/sex profile of the practice shows the practice has slightly fewer patients in the 20 to 39 year age group compared to the national average; and slightly more patients in the 60 to 85 year age group than the national average. The average life expectancy for patients at the practice is 80 years for men and 82 years for women, compared to the national average of 79 years and 83 years respectively.

The practice offers a range of enhanced services which include childhood vaccination and immunisation, facilitating timely diagnosis and support for people living with dementia and minor surgery.

The clinical team comprises three GP partners; all male and four salaried GPs, two male and two female. There are five advanced nurse practitioners, four female and one male; three female practice nurses and four health care assistants, all of whom are female. The clinical team is supported by a practice manager and a range of administrative, secretarial and reception staff.

The practice is open between 8am and 6pm Monday to Friday. Appointments are staggered throughout the day to optimise patient access. Extended hours are available on Monday and Wednesday evening between 6.30pm and 8pm; and on Tuesday and Thursday morning between 7am and 8am. The surgery is located in 1970s purpose built premises. Staff from the local community health trust share the building. All clinical rooms for the practice are located on the ground floor. Car parking is available on site, and the building is accessible to patients with mobility difficulties, or those who use a wheelchair.

Out of hours care is provided by Local Care Direct which is accessed by calling the surgery telephone number, or by calling the NHS 111 service.

When we returned for this inspection, we checked and saw that the previously awarded ratings were displayed as required in the premises and on the practice website.

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 abuse.

- The practice conducted safety risk assessments. It had a suite of 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 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, and were able to provide clear examples from practice where appropriate action had been taken.
- 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).
- 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. Equipment such as blood pressure monitoring equipment and thermometers were cleaned after use. At the time of our inspection no written log to evidence cleaning of these was in use. The practice told us they would implement a system of logging this.
- 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.

- Staff rotas were developed for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- 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. The clinical records provided 'sepsis alerts' to further guide clinical assessment.
- The practice proactively managed current or planned changes to services or staff to optimise patient safety. We saw that appropriate succession planning was in place for all staff groups.

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. The practice had completed an audit of how information was shared with out of hours services. They were able to demonstrate how appropriate information sharing had been increased and improved.
- Referral letters were comprehensive and included all of the necessary information.

Safe and appropriate use of medicines

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

Good

Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship. The practice performed well against benchmarked prescribing data within their local GP cluster.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice 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.
- 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 they felt able to raise issues and were supported by GPs and the practice manager in doing so.
- There were clear 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 an incident had occurred where a sample bottle was incorrectly labelled with another patients' details. As a result, personal clinical work streams were developed to include witness checking of sample labelling and bagging.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

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 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.
- Prescribing rates for hypnotics were in line with national averages. Hypnotics are a range of medicines which work on the central nervous system to relieve anxiety, aid sleep or have a calming effect.
- Prescribing rates for antibacterial items were in line with national averages.
- Prescribing rates for Co-Amoxiclav, Cephalosporins or Quinolones were in line with national averages. These antibiotics should only be used in specific circumstances or when other antibiotics have failed to prove effective in treating an infection.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- Patients were able to access an online symptom checker and health A-Z via a link on the practice website. Free Wi-Fi was available on site in the practice.

Older people:

- The practice was in the process of adapting a local frailty assessment tool. 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.
- The practice provided medical care for three nearby nursing and residential homes for older people. Before the inspection we sought feedback from one of these, who confirmed that the practice provided a high level of support and appropriate care for these patients.
- The practice followed up on older patients discharged from hospital. Care plans and prescriptions were updated when appropriate, to reflect any new or changed needs.
- Patients over 65 years were encouraged to take up an annual seasonal flu vaccination. We saw that 78% of eligible patients in this age group had received the vaccination in 2016/17, compared to the national average of 71% uptake

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. Reviews were offered in September and October where possible to coincide with the seasonal flu vaccination programme. The GPs worked with the local multidisciplinary teams to co-ordinate and plan care for those patients with more complex needs.
- The practice delivered level three diabetic care, which meant that injectable treatments could be initiated and monitored in house without the need to attend hospital outpatient appointments.
- Staff who were responsible for reviews of patients with long term conditions received appropriate training and regular updates.
- 82% of patients with diabetes on the register had a recorded HbA1c which was within normal limits within the preceding 12 months, which was higher than the CCG average of 78% and the national average of 80%. HbA1c monitors the level of glucose in the haemoglobin in the blood. The higher the HbA1c the greater the risk of developing complications related to diabetes.
- 83% of patients with asthma, on the register had a review completed in the preceding 12 months, which was higher than the CCG average of 80% and the national average of 76%.
- 92% of patients with Chronic Obstructive Pulmonary Disease (COPD) had a review completed which included an assessment of breathlessness in the preceding 12 months, which was the same as the CCG average, and higher than the national average of 90%.
- 88% of patients with hypertension had a recorded blood pressure which was within normal limits, which was higher than the CCG average of 85% and the national average of 83%.
- 90% of patients with atrial fibrillation had received treatment with anti-coagulant therapy in the preceding

Good

Are services effective?

(for example, treatment is effective)

12 months, which was higher than the CCG average of 89% and the national average of 88%. Atrial fibrillation is a heart condition which causes an irregular and often abnormally fast heart rate. People with atrial fibrillation may be at higher risk of stroke or heart attack.

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, other than for children aged two years who had received the pneumococcal booster vaccine; of these 83% had received this vaccination. Childhood vaccinations and immunisations were carried out by a local immunisation team and were not managed by the practice. However, we were made aware that there was a supply issue in relation to this vaccine. The practice was forward planning for a time when the practice took over responsibility for delivering the childhood immunisation programme. They told us all relevant staff had received the training required, and additional staff had been recruited to meet this need.
- The practice hosted a weekly midwifery clinic, and liaised as appropriate to monitor the health and well-being of women during pregnancy.
- New baby checks were provided by the practice for babies between six and eight weeks old.
- 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 cervical screening was 80%, which was in line with the 80% coverage target for the national screening programme and was higher than the CCG average of 73% and national average of 72%.
- 79% of eligible females had accessed screening for breast cancer in the preceding three years, which was higher than the CCG average of 66% and national average of 70%.
- 65% of eligible patients had been screened for bowel cancer in the preceding 30 months compared to the CCG average of 49% and national average of 53%.
- 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.

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 liaised with community nurses and palliative care nurses to manage and plan care for this group of patients.
- The practice provided outreach support to a nearby homeless hostel for people with drug and alcohol difficulties. The GPs attended the hostel to raise awareness of the support available from the practice. Other homeless people were able to use the practice address as a home address for administrative purposes to ensure effective communication between other agencies.
- The practice held a register of patients with learning disability. At the time of our inspection there were 66 patients on the register. These patients were offered an annual health review.
- A carers' champion had been appointed in the practice. They had identified 106 people (1% of the practice population) as carers at the time of our inspection.

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

- 89% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher than the CCG and national average of 84%.
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was higher than the CCG average of 91% and the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 92% of patients experiencing poor mental health had received discussion and advice about alcohol consumption compared to the CCG and national averages of 92% and 91% respectively. In addition 96% of patients

Good

Are services effective?

(for example, treatment is effective)

experiencing poor mental health had received discussion and advice around smoking cessation compared to the CCG and national averages of 97% and 95% respectively.

- The practice hosted an IAPT (improving access to psychological therapies) clinic to support people who were experiencing emotional or psychological difficulties.

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, they had completed an audit of completed palliative care forms used to share patient information with out of hours' services. We saw that the percentage of fully completed forms had increased from 45% in March 2016, to 89% in March 2017. Where appropriate, clinicians took part in local and national improvement initiatives. For example they benchmarked their practice against their local GP cluster, examining and evaluating a number of indicators, such as referral rates and prescribing data.

The most recent published Quality Outcome Framework (QOF) results (2016/17) were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall exception reporting rate was 5% compared with the CCG average of 9% and the national average of 10%. QOF is a system intended to improve the quality of general practice and reward good practice. 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.

- The practice used information about care and treatment to make improvements. For example a piece of work had been carried out to identify and treat patients at risk of calcium and vitamin D deficiency, in line with national guidance. As a result 198 patients were called in for review and prescribed the appropriate supplementary medicines. This meant that the risk of bone fractures in this group of patients was reduced.
- The practice was actively involved in quality improvement activity. For example they reviewed patients with asthma, and found a number of patients whose asthma was not well-managed. As a result affected patients were invited to attend for a review to adjust their preventative and treatment plans. Where appropriate, clinicians took part in local and national improvement initiatives. They demonstrated that they had reduced their prescribing levels for hypnotics, through signposting to alternative support services such as local pain management support services.

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. We were given several examples of how staff had been supported to develop and change role or extend their expertise within their role. For example, a receptionist had been encouraged to acquire the necessary skills to become a health care assistant, and two practice nurses had been supported to complete their nurse practitioner training.
- The practice provided staff with ongoing support. This included an induction process, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. Advanced nurse practitioners attended a weekly clinical meeting in which clinical cases were discussed and learning shared.
- There were systems in place for supporting and managing staff when their performance gave cause for concern.

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 that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- 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.
- The practice held monthly multidisciplinary meetings with community staff such as health visitors, district nurses and palliative care nurses. We saw that patient records were updated following such meetings to reflect decisions agreed or changes to care plans.

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.
- 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. Smoking cessation services were available in house, provided by the health care assistants. Patients needing support to lose weight could be referred to local weight management 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. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff had received training in mental capacity to the appropriate level.
- The practice monitored the process for seeking consent appropriately.

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.
- 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.
- The 25 patient Care Quality Commission comment cards we received were positive about the service experienced, in all but one case. This was in line with the results of the NHS Friends and Family Test and other 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. There were 231 surveys sent out and 94 were returned. This represented 41% of the surveyed population and 1% of the practice population. The practice was largely comparable with others for its satisfaction scores on consultations with GPs and nurses. For example:

- 72% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 74% of patients who responded said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- 92% of patients who responded said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 74% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 86%.
- 87% of patients who responded said the nurse was good at listening to them compared to the CCG and national average of 91%.
- 89% of patients who responded said the nurse gave them enough time compared to the CCG average of 91% and the national average of 92%.
- 94% of patients who responded said they had confidence and trust in the last nurse they saw compared to the CCG and national average of 97%.
- 84% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 91%.
- 82% of patients who responded said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

The practice showed they had evaluated and reviewed these results. In order to improve patient experience the practice had recruited an additional receptionist. All receptionists had received customer service training. Appointment availability and staff training had been staggered throughout the day to increase the number of available appointments with clinicians; and additional telephone lines and computer terminals had been made available to reception staff. We also saw that GPs and other clinicians had undergone a process of reflection and learning where patients had described a less than positive experience during consultations.

Involvement in decisions about care and treatment

Staff helped patients 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):

- Telephone 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, picture books were available to assist patients with learning disabilities.
- A hearing loop was available for patients with hearing impairment, and British Sign Language (BSL) interpreters could be accessed when required.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Good

Are services caring?

The practice proactively identified patients who were carers, at the point of registration and opportunistically during consultations. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 106 patients as carers (1% of the practice list).

- A carers' champion had been appointed from among the staff group. This helped raise the profile of carers in the practice; and enabled eligible patients to be signposted to local carers' support groups and other relevant services. Carers were able to accompany the person for whom they were caring during consultations when appropriate.
- Staff told us that if families had experienced bereavement a condolence card was sent in appropriate circumstances. GPs also offered home visits to support families where there had been a period of illness before the bereavement occurred.

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

- 74% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 69% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 85% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 90%.
- 81% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

During the inspection we observed interaction between staff and patients, both face to face and on the telephone. We saw that patients were treated with kindness, good humour and gentleness. Patients we spoke with on the day of the inspection also confirmed this impression.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- A previous inspection had identified a lack of confidentiality in the nurse waiting area, where conversations in consulting rooms could be overheard. The practice had made efforts to ameliorate this by changing the position of the seating in the area away from consulting room doors. In addition they had added background music in the waiting area in order to enhance confidentiality during consultations.

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 across all population groups.

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. In response to lower than average patient survey results for access to appointments the practice had added two additional phone lines for incoming calls. They had increased the amount of available face to face appointments, and introduced a combination of book on the day and advance booking appointments. Online services were available, and health information was accessible via the practice website. At the time of our inspection the practice had not as yet undertaken further patient satisfaction surveys to gauge the response to these improvements.
- Extended hours were available on Tuesday and Thursday morning between 7.00am and 8am; and on Monday and Wednesday evening between 6.30pm and 8pm
- 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 home visits were readily available for those patients who were housebound or too unwell to attend surgery. A dedicated phone line was in place for patients requiring home visits.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- The practice worked closely with the multidisciplinary team, including palliative care nurses and district nurses to co-ordinate and plan care for this group of patients.
- The practice provided GP services to three local nursing/residential homes for older people. Before the inspection we sought feedback from one of these. They told us they received a responsive and efficient service from the staff at the practice.
- The practice was responsive to the individual needs of older patients. A dedicated line was provided for patients requesting home visits.
- The practice was in the process of adopting a frailty register which enabled them to identify patients of higher risk of illness or injury.

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. Appointments were offered around September or October when possible, in order to coincide with the seasonal flu vaccination.
- The practice was proactive in promoting update of the seasonal flu vaccination. 'Team Flu' was created, staff wore tee shirts, stating "I'm a flu fighter" to promote awareness of the vaccine within the eligible patient group.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice provided level three diabetic care to patients with diabetes. This enabled them to initiate and monitor injectable treatments, which avoided the need for patients to attend hospital outpatient appointments.

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.
- Staff told us children were given priority appointments when requested.
- The practice met with health visitors on a monthly basis, where children and families of concern were discussed, and any decisions or changes to care planning were documented in the patient record. GPs told us they provided reports for child protection meetings when requested.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice had links with the local primary school and attended to give talks to children to highlight the services provided by the practice. The school reciprocated by provision of a regularly updated decorative wall mural for the GP waiting area.

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

- The practice offered online access to book appointments and request repeat prescriptions.
- Extended hours appointments, including nurse appointments, were available on Monday and Wednesday evening from 6.30pm to 8pm; and on Tuesday and Thursday morning between 7am and 8am.
- Telephone call-backs were available for patients unable to attend the surgery in person during working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice provided outreach to a nearby homeless hostel for people with drug and alcohol dependency problems. GPs visited the hostel to highlight the services the practice was able to provide. Other homeless people were able to register with the practice, and use the practice address as a home address for administrative purposes.
- The practice held a register of carers, and offered these patients access to regular health reviews and the annual seasonal flu vaccination when appropriate.
- The practice was identified as a 'Safe Place'. This was intended to provide a safe haven for people with learning disabilities when they were away from familiar surroundings such as their home.

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

- The practice held a dementia register, and utilised tools to help identify early signs of dementia.
- The practice hosted an Improving Access to Psychological Therapies (IAPT) clinic to support people experiencing emotional and psychological difficulties.
- The practice liaised with local mental health support services to co-ordinate care for patients experiencing mental health difficulties.

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 managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The practice had responded to patient survey results which indicated some lower than average scores in relation to accessing the surgery by telephone, available appointments and time waiting to be seen. They had added two additional telephone lines for incoming calls, had recruited an additional receptionist, and had amended clinician's rotas to increase the number of available appointments.

Results from the national GP patient survey (conducted during the period January to March 2017) showed that patients' satisfaction with how they could access care and treatment was lower than local and national averages. This however was not supported by our discussions with patients on the day of the inspection, nor on the CQC comments cards we received. Comments cited staff as "courteous and caring, treated with respect", patients described feeling "listened to" during anxious times.

- 62% of patients who responded were satisfied with the practice's opening hours compared with the CCG average of 73% and the national average of 76%.
- 53% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 67% and the national average of 71%.
- 80% 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 to the CCG average of 81% and the national average of 84%.
- 73% of patients who responded said their last appointment was convenient compared to the CCG average of 79% and the national average of 81%.
- 58% of patients who responded described their experience of making an appointment as good compared to the CCG average of 68% and the national average of 73%.
- 46% of patients who responded said they don't normally have to wait too long to be seen compared to the CCG average of 59% and the national average of 58%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was aware of these results, and was working on improving access to the service. We saw an audit, completed in February 2018, which showed:

- The number of abandoned calls had reduced from 200 in January 2017 to 84 in January 2018.
- Average wait times to be seen had reduced from seven minutes in January 2017 to just over five minutes in January 2018.
- The number of annual available appointments had increased from 5,285 in January 2017 to 5,707 in January 2018.
- The average number of face to face appointments offered equated to 89 per 1,000 patients per week.

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. Ten complaints were received in the last year. We reviewed two complaints in detail, 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 a complaint was received in relation to the manner of a clinician during a consultation. As a result the patient received an apology and further explanation; and learning was shared at the clinical meeting, enabling the clinician to further reflect upon the conduct of the consultation.
- At the time of our inspection we saw that the practice did not have a system to collate and record informal, verbal complaints. The practice told us they would review their approach in relation to this.

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.
- Leaders at all levels were hands on, visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice GP team had been stable since 2014. We saw there was a low turnover of staff, with many staff having worked at the practice for over ten years. We saw that staff were encouraged to develop leadership capacity and skills. Succession planning was in place for all levels of staff.

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 a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patient participation group members and staff.
- 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.
- The practice monitored progress against delivery of the strategy.

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 prioritised a high level of individualised care for patients.
- Where behaviours and performance were out of step with the practice vision and values, the leadership team had policies and procedures in place to address these.
- 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 had received an appraisal in the preceding year. Staff were supported to meet the requirements of professional revalidation where necessary. We were given examples of how staff had been supported to enhance their skills, learn new skills and develop into new roles within the practice.
- 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.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- Staff described positive relationships amongst all colleagues and leaders.

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 interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control

Are services well-led?

Good

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

- Practice leaders had established proper 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 an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints. We saw minutes from meetings which showed that key quality and strategic issues were discussed and reviewed routinely.
- 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 emergencies.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

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.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust 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.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, in response to a suggestion by the patient participation group, a leaflet was produced and hand delivered to local addresses providing detail and information about the practice, their staff, and the services they provided. This was intended to raise awareness amongst the population that the GP practice staff were stable, and to encourage patients to access the service appropriately.
- The practice engaged with the local community to raise the profile of the practice. They provided sponsorship to a local girls' football club. In addition they provided outreach to a nearby homeless hostel. They also had a reciprocal arrangement with the local primary school, where the school provided a decorative mural for the GP waiting area in the practice, and practice staff visited the school to explain how GP services run.
- A patient participation group was established. A core membership of eight to ten people attended, however the group was keen to attract a wider range of patients, in line with the demographics of the patient population. They were establishing a social media profile, and exploring ways of attracting 'virtual' PPG members to the group.
- 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. Staff had been encouraged and enabled to develop and enhance their skills and change roles within the practice.

Are services well-led?

Good

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

- The leadership team were involved in their locality GP hub to collaborate on providing outlines for new models of care to meet the changing needs of the patient population.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out during protected learning time, to review individual and team objectives, processes and performance.