Dr Wilcox & Partners

Quality Report

Essex House Medical Centre
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Chard
Somerset
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection 26/11/2014 – was overall rated as Good)

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 Dr Wilcox & Partners at Essex House Surgery on 20 December 2017. This inspection was carried out as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice 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.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- There was a focus on continuous learning and improvement within the practice. For example, improved guidelines for clinical staff in regard to medicines management which was shared across to other GP services in the federation.

Summary of findings

- The practice has set aside a 'safe' area with telephone access and information for vulnerable people to have access to seek support from external organisations. Such as help for domestic abuse.
- The regular multi-disciplinary meetings held with the Health Visitor, Midwife and School Nurse team have been recognised as best practice by the Somerset Clinical Commissioning Group Safeguarding Nurse.
- The practice at the time of the inspection had on-going IT issues which had impacted upon the speed and flexibility of using patient records, templates and IT work streams. Support had been sought from the providers of the IT systems and the practice were still awaiting them to be resolved. Although challenging for the staff, they had implemented workarounds to ensure that patients care and support was not compromised.

There was an area that was outstanding:

- The practice had been recognised for its work in monitoring high risk medications as it was one of five GP practices from across the country nominated for the National Prescribing Safety Awards 2017.

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

- The practice had detailed information of the recruitment and selection process although they should consider recording the identity of the members of staff conducting the interview and selection process to aid a good audit trail.

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

Dr Wilcox & Partners

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.

Background to Dr Wilcox & Partners

Essex House Surgery is located at 59 Fore St, Chard, Somerset, TA20 1QA. The service had approximately 8,787 patients registered from around the local and surrounding areas. Patients can access information about the service at www.essexhousemedicalcentre.org.uk

The service is located on a main thoroughfare in the centre of Chard. There is a small car park and disabled parking bays to the rear of the building. Further parking is a short walk away in a public car park. The front of the building, Grade two listed, has been adapted where possible to meet the needs of the service. To the rear is a purpose built extension that provides adequate consulting and treatment areas on the ground floor that is accessible to patients with limited mobility.

The practice partnership consists of four GP partners who employ one salaried GP. There are two male and three female GPs. The practice employed two nurse practitioners, four practice nurses and three health care assistants. The practice has a practice manager who is supported by a team of management staff, reception staff, administrators and secretaries.

The practice is open from 8.00am Monday to Friday until 6.30pm. Extended hours until 8pm are available on alternate Wednesday and Thursday evenings. In addition, working in conjunction with other practices in the area they open in the evening for nine Fridays per year until 8pm and nine Saturday mornings from 8.30am to 11.00 am per year. Patients have the option of attending late evening and Saturday morning surgeries at other local practices who are participating in a Somerset Clinical Commissioning Group, Improved Access Pilot Scheme.

The practice has a General Medical Services (GMS) contract with NHS England (a locally agreed contract negotiated between NHS England and the practice). The practice is contracted to deliver a number of enhanced services including; extended hours access for patients, childhood immunisations, enhanced services for the assessment and provision of services for patients living with dementia and minor surgery.

The practice does not provide out of hours services to its patients, this is provided via NHS111 Contact information for this service is available in the practice and on the practice website.

Demographic data from 2015/2016 that is available to the CQC shows:

The age of the patient population was similar to the national averages for patients under the age of 18 years at 18%, the national average being 20%. For patients over 65 years the practice has 25% with the national average being 17%.

Other Population Demographics included 60% of the practice population had a long standing health condition, which was above the national average of 54%. Also 54% of patients were in paid work or full time education which was below the national average of 62%. Information from the

Index of Multiple Deprivation 2015 (IMD): showed the practice population is at 20 (the national average 21). The lower the number the more affluent the general population in the area is.

Detailed findings

Income Deprivation Affecting Children (IDACI): is 16% (the national average 20%)

Income Deprivation Affecting Older People (IDAOPI): is 13% (the national average 17%).

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 training 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.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an on-going basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).The practice had detailed information of the recruitment and selection process although they should consider recording the identity of the members of staff conducting the interview and selection process to aid a good audit trail.
- 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. There was a lead member of staff who managed infection control at the practice and a programme of audits and checks including the hand washing technique for all clinicians.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff told us that clinicians were flexible and carried out tasks such as blood testing at the time of appointments to reduce the need for patients to return to see another member of staff at a later date.
- There was an effective induction system for temporary staff tailored to their role. This included detailed information for locum GPs to guide them to records and local information about services available.
- 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. Key information was on display in consulting and treatment rooms as a reminder and for guidance should it be required.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. Patients had individual named GPs and staff endeavoured to ensure patients were able to see their named GP where possible. The care records we saw showed that information needed to deliver safe care and treatment was detailed and was available to other relevant staff in an accessible way if this could not be achieved. Feedback from patients showed that there was continuity of care irrespective of seeing their named GP.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe

care and treatment. This was through detailed electronic records, regular meetings within the GP practice and with other external health care professionals.

- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The 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.
- 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.
- The practice jointly employed with the GP federation and clinical commissioning group a clinical pharmacist who carried out various roles including post discharge from hospital domiciliary home visits for medication reviews with patients. The pharmacist also had oversight and instigated medicines audits and identified patients with long term conditions that required medication reviews. In conjunction with the GPs from the practice, they had instigated recommendations for drug monitoring. Guidance was on displayed in all consulting and treatment rooms to assist staff and had been shared with other GP practices in the local area.
- The practice had been recognised for its work in monitoring high risk medications as it was one of five GP practices from across the country nominated for the National Prescribing Safety Awards 2017.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. These were regularly reviewed and updated when required.
- 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 appropriate 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. Specialist advice from outside the organisation was sought when required. Information was shared across the whole team to encourage shared learning and innovation. For example, there was a near miss event by another health care agency where a patient almost received an incorrect dose of medication that may have impacted on their on-going treatment for heart disease. This event was reviewed and joint working ensured that a new protocol was put in place which included the introduction of a reminder or prompt label applied to the patients anti-coagulant medicine record book as an alert to discuss with a clinician or to take additional action. Significant events, the outcomes and actions taken to prevent reoccurrence were revisited and reviewed in regular significant event meetings.
- 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. Clinical templates were adjusted and updated in accordance to any new clinical advice received in. For example, recording oxygen saturation levels were added to the asthma management template. This meant there was a consistent approach to assessing and planning patients care.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice provided Doppler assessments, a test to check a patients circulation in a limb at the practice in order to prevent having to go elsewhere for assessment.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are 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 and assessment for the falls prevention.
- The practice monitored patients aged over 75, they had identified that 11.5% of their patient population were in this group and were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- Home visits organised for annual influenza vaccines and or shingle vaccines for vulnerable patients. The practice liaised with the community nurse teams so that patients did not miss out.
- The practice followed up on older patients discharged from hospital this was through using the shared GP federation pharmacist to check discharge medicines on a domiciliary visit. If they found any issues this was reported back to the GPs and who ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice hosts Abdominal Aortic Aneurysm (AAA) clinics, where males over 65 years old are offered ultrasound screening. They implemented additional clinics for those 70-71 year olds who missed out receiving the invitation when it was initiated. Of these additional patients 248 were identified, 140 took up the invitation and three patients were identified as having an aneurysm. Overall nine patients have been identified as having an AAA and have been referred to the appropriate secondary health care service and/or received care and support from the practice.
- The practice has instigated with the district nursing team support a monitoring system for injectable medicines, those medicines with a specific timescale and window to be given. This was to ensure they continued to receive effective treatment.

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.
- Newly diagnosed diabetics were referred to the local educational programme (DESMOND) to improve their lifestyle and diet and were reviewed by the practice nurses every six months.
- The practice had identified it needed to expand the skill set and numbers of the nursing staff to meet the needs of the patients it supports. A second nurse had attained a diploma in asthma care. Extra nursing clinic sessions had been implemented including evenings clinics.

Good

Are services effective?

(for example, treatment is effective)

- Changes in the appointment timings had occurred and the practice could offer a mixture of 15 or 10 minute appointments during the day which could accommodate additional GP home visits should it be required.
- Using the shared GP federation emergency care practitioners to carry out home visit assessments/ consultations enabled patients to be seen earlier and the GPs to focus on those patients who required the experience and knowledge of the GP.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccine programme. The practice held weekly child immunisation clinics. To ensure attendance all parents received a telephone call in the morning before the afternoon clinic to remind them or to rebook appointment should it be required. Uptake rates for the vaccines given were above 97.8 – 99.9%; the target percentage was 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice offered a full range of contraceptive implants and sexual health screening. Changes in the local services for contraceptive health had identified there was a greater need for the clinical skills at the practice to enable offering a female IUD(intrauterine contraceptive device) fitter, a second GP has just completed the necessary training to undertake this task.
- The practice has a young person's champion to provide support for young people to access services and who works with the local schools with providing support and information.

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

- The practice's uptake for cervical screening was 81%, which was in line with the 81% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time, as these people were deemed to be of higher risk.
- Patients had access to appropriate health assessments, such as weight and blood pressure checks, and smoking cessation support. Patients were signposted to NHS checks for patients aged 40-74 that were carried out by another provider. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had an advance booking system for appointments out of their core working hours for evening and Saturday morning appointments.

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. One of the GPs was lead for palliative care at the practice and had oversight of patients receiving care and support for palliative care and treatment. Every six to eight weeks meetings were held with district nurses and the local hospice team to review and coordinate patients care needs. GPs visited palliative care patients at least monthly to check on their care and wellbeing.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice has installed a phone in a side room for vulnerable patients or patients suffering from domestic abuse to use and have created a folder of useful contacts and information for them to use.

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

- One of the GPs acted as the mental health lead for the practice and has ensured that there is an up to date register of patients who have a mental health illness or mental health problems.
- The practice had a higher incidence of patients over the age of 18 years of age with a diagnosis of depression just below 13%, the clinical commissioning group (CCG) 10% with the national average 9%.
- The practice has implemented an alert on patient's records for those patients with an increased risk of dementia.
- Patients have access to a self-referring Talking Therapies service.

Good

Are services effective?

(for example, treatment is effective)

- 88% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is above the national average of 84%.
- 87% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. The national average being 90.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 95%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 99%; CCG 90%; national 95%).
- The practice has implemented an alert on patient's records for those patients with an increased risk of dementia.

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. The practice has continued to use information gathered for the national Quality Outcome Framework (QOF) to provide a baseline or register of patients at higher risk and need for support. QOF is a system intended to improve the quality of general practice and reward good practice. Somerset Clinical Commissioning Group had implemented the Somerset Practice Quality Scheme (SPQS). The aims of the scheme were to actively monitor performance and improve the quality of general practice.) The practice had opted out of participating in SPQS. The practice have used this QOF information effectively which can be seen by the consistently high scores in comparison with the national levels across all key areas.

For 2016/17, there were a maximum of 559 points available to practices across QOF, which in turn determine payments. Payments were subject to certain thresholds (targets) and took account of the national prevalence of diseases, by applying a standard calculation to all practices. In 2016/17 Dr Wilcox & Partners achieved 557 QOF points.

The overall exception reporting rate was comparable or lower than the national average. (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 performance was lower than the national average for exception reporting which shows the practice were effective in ensuring patients were compliant with attending for assessment, care and treatment to meet their needs and there were good systems in place for recording detailed information when patients attended the practice:

- In those patients with atrial fibrillation with a record of a CHA2DS2-VASc (risk of stroke) score of 2 or more, the percentage of patients who were currently treated with anticoagulation drug therapy was 98%, the CCG average 85% the national average 88% (01/04/2016 to 31/03/2017).
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 92%, the CCG average was 77%, the national average 84% (01/04/2016 to 31/03/2017).
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017).
- The practice used information about care and treatment to make improvements.For example prompted by a near miss event, the practice had a dedicated member of staff to monitor patients who were on injectable medicine treatments that could either be given by the practice nurses or the district nursing team. This had reduced the risk of double dosing or missed dose and ensured that blood testing, medicines ordered in good time, the medicines administration records were correct and information brought to the GPs attention.
- Checks were also made in regard to any intervention for these patient made by NHS111, Out of Hours, A&E and any local Minor Injury Units (MIU).

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.

Good

Are services effective?

(for example, treatment is effective)

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- We had positive feedback in regard to the strong mentorship for clinicians at the practice as one of the GPs at the practice had been commended by GMC (General Medical Council) for their support given to a GP struggling in an earlier part of their career.
- Feedback from staff showed that good support is given to locums who are included in meetings, clinical discussions and how the service is provided.

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

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- 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, stop smoking and tackling obesity campaigns.

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.
- 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.
- All of the 35 patient Care Quality Commission comment cards we received were positive about the service experienced. This is 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. 226 surveys were sent out and 124 were returned. This represented about 1.4% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 81%.
- 99% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 96%.
- 98% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 89%; national average - 86%.
- 99% of patients who responded said the nurse was good at listening to them; CCG - 93%; national average - 91%.
- 99% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.

These higher than average scores are reflected in the feedback from patients in the comment cards we received. Patients used words such as 'compassionate', 'friendly', 'helpful' and expressed how the staff made them feel relaxed and less anxious about their care.

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):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- 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.

The practice proactively identified patients who were carers. This was recorded as patients registered with the practice, when they attended appointments and through highlighting leaflets and information in public areas of the practice. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 119 patients as carers (1.5% of the practice list). This figure of 1.5% is lower than similar practices within the clinical commissioning group.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective. The practice told us that they provided a carers pack and were from January 2018 proposing to hold a monthly clinic to support carers.

- Staff told us that if families had experienced bereavement, their usual GP contacted them and

Good

Are services caring?

always sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the national GP patient survey (2017) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 97% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 87%.
- 93% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average - 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 86%.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The practice improved services where possible in response to unmet needs.
- 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 for patient unable to attend through ill-health and mobility problems.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice was always looking to provide services within the community such as hosting other services like retinal screening, Aortic Aneurysm screening, sexual health support and counselling so that patients did not need to travel outside of the area to receive appropriate care.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- The practice had identified patients and held a register of who had long term conditions so that they could target their care appropriately to meet their needs. For example, conditions such as diabetes (627), asthma (625), COPD (Chronic Obstructive Pulmonary Disease) (223), Chronic Heart Disease (352) and Stroke (230). Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. The practice regularly offered 15 minute appointment slots each day for patients who fell into this category.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients could be seen by other clinicians on home visits such as the pharmacist or the emergency care practitioner so that their on-going care and treatment plans were reassessed and their needs met without having to wait too long to have an appointment at the practice.

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. 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.
- The regular multi-disciplinary meetings held with the Health Visitor, Midwife and School Nurse team have been recognised as best practice by the CCG Safeguarding team.

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 and Saturday appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice has set aside a 'safe' area with telephone access and information for vulnerable people to have access to seek support from external organisations. Such as help for domestic abuse.

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 who have depression were seen regularly and were followed up if they did not attend.
- The practice maintained communication and worked well with the community mental health team and had the ability to refer and seek assistance for urgent intervention if required.

Timely access to the service

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

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

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed CQC comment cards.

- 84% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 83% and the national average of 80%.
- 80% of patients who responded said they could get through easily to the practice by phone; CCG – 77%; national average - 71%.
- 73% 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; CCG - 82%; national average - 76%.
- 84% of patients who responded described their experience of making an appointment as good; CCG - 78%; national average - 73%.

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. Two complaints were received in the 12 months. We reviewed these complaints and found that they were satisfactorily handled in a timely way. We also looked at complaints received prior to this period and saw that complaints were occasionally further raised as significant events and vice versa.
- 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, delays in appointment times led to the introduction of a variety of appointment length of times during the day. Patients could indicate that they would need a 15 minute appointment or longer to accommodate their needs.

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 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 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.

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 patients, staff and external partners.
- 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. Staff fed back that they were able to make suggestions and raise issues and these were listened to and acted upon.
- The practice focused on the needs of patients.
- Leaders and managers acted on staffs behaviour and performance inconsistent with the vision and values of the practice.
- 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. Time and financial support were given to staff to enable access to training to enhance their roles within the practice. All staff had 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 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.
- There were positive relationships between staff and teams.

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,

Are services well-led?

Good

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

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. There was evidence of good communication between staff and different teams so that there was a team approach to activities and the delivery of the service.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. These policies and procedures were reviewed and updated on a regular basis.

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.
- 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.
- 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.
- The practice at the time of the inspection had on-going IT issues which had impacted upon the speed and flexibility of using patient records, templates and IT work streams. Support had been sought from the providers of the IT systems and they were still awaiting them to be resolved. Although challenging for the staff, they had implemented workarounds to ensure that patients care and support was not compromised.

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 areas for improvement.
- 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 full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group who confirmed that they were listened to and encouraged to participate and comment on how the service was run.
- The service was transparent, collaborative and open with stakeholders about performance.

Are services well-led?

Good

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

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement within the practice. For example, improved guidelines for clinical staff in regard to medicines management which was shared across to other GP services in the federation.
- 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.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.