Upton Surgery

Quality Report

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

Ratings

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

Key findings

Contents

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Upton Surgery on 13 February 2018 as part of our inspection programme.

At this inspection we found:

- The practice had comprehensive systems in place to manage and monitor risks to patients, staff and visitors. This included risks to the building, environment, medicines management, staffing, equipment and a range of emergencies that might affect operation.
- The practice continued to achieve 100% on the Quality Outcomes Framework and had an overall low exception reporting rate.
- The practice routinely reviewed the quality and effectiveness of the care it provided. Care and treatment was delivered according to evidence based guidelines. We saw that a wide range of clinical audits were carried out and there was a whole practice approach to improvement.
- The leadership, governance and culture were used to drive and improve the delivery of its service. All staff were involved in the development of the practice and were proud of their achievements.
- The practice reviewed the needs of their local population and had initiated positive services for patients.
- Staff 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.
- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility and choice. For example, Saturday appointments improved access for patients who were unable to attend appointments during working hours.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. There was a strong focus on continuous learning and improvements at all levels in the practice. When incidents did happen, the practice learned from them and improved their processes.
- There was evidence that service improvement was a priority among staff and leaders. High standards were promoted by all practice staff and there was strong team working and a commitment to personal and professional development.

We saw several areas of outstanding practice:-

- The practice was forward thinking to improve the outcomes for patients in the area. There was a clear approach to seeking out and integrating services to

Summary of findings

improve patient care. It sought out opportunities to engage with the community and provide a range of accessible services to meet the needs of its population.

- The practice understood the rurality and challenges of its practice population and developed a strategy to build responsive services in line with health and social care priorities across the region. There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. Strategies and plans were aligned in the wider health economy and there was a demonstrated commitment to a system wide collaboration and leadership.
- There was clear, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver sustainable care. There were deeply embedded systems of leadership which aimed to ensure that senior staff had considered the needs for the future.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Outstanding**
Are services well-led?	**Outstanding**

Summary of findings

The six population groups and what we found

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

Older people	Outstanding ☆
People with long term conditions	Outstanding ☆
Families, children and young people	Outstanding ☆
Working age people (including those recently retired and students)	Good ●
People whose circumstances may make them vulnerable	Outstanding ☆
People experiencing poor mental health (including people with dementia)	Good ●

Upton Surgery

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, a member of the CQC medicines team and a second CQC inspector.

Background to Upton Surgery

Upton Surgery provides care for approximately 10,949 patients. The service covers Upton upon Severn and 15 surrounding rural villages within an area of 70 square miles. The practice holds a General Medical Services contract, a nationally agreed contract. The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.

There was a higher than average patient age of 45 to 85+ years of both sexes registered at the practice. There was lower than average population group of age 0 to 44 years of both sexes.

The practice provides care for 100 patients who are aged 90 years or over and 177 registered patients who reside in six nursing and care homes. Patients in care homes have a designated GP who visits weekly. The lead nurse for older people also visits these patients.

The premises were purpose built with all consulting rooms located on the ground level for ease of access for patients who have limited mobility. There is a dedicated car park and some spaces are allocated for disabled patients.

The practice has six GP partners and one salaried GP. GPs are supported by two advanced nurse practitioners (prescribers) who between them spend 65.5 hours seeing patients with minor ailments. There are four practice nurses (one was the lead for older patients and a prescriber) and four health care assistants (HCAs) who provide cervical screening, vaccinations, reviews of long term conditions and phlebotomy (taking blood samples) services. There is also a full time phlebotomist. A full time pharmacist has taken the role of practice manager but continues to oversee the dispensary and provide advice to GPs and advanced nurse practitioners. The practice employs a practice director (manager) who has a personal assistant, and an assistant practice manager. They are supported by administration staff, a senior administrator, an administrator and an administrator/receptionist. There are seven receptionists, one business administrator and a medical secretary. There is a dispensary team leader, seven dispensers, three dispenser assistants and two drivers.

The practice is a designated training practice for trainee GPs. These are qualified doctors who are learning the role of a GP. Clinical staff also provide training for medical students from Warwick Medical School.

The practice offers a range of clinics for chronic disease management, diabetes, chronic obstructive pulmonary disease (COPD) heart disease, asthma, cervical screening, contraception advice, minor surgery, anticoagulation, injections and vaccinations. The practice is open from 8am until 6.30pm every weekday.

The practice offers a range of services. For example, management of long term conditions such as diabetes, contraceptive advice, immunisations for children, travel vaccinations, wound management, podiatry, chiropractor, retinal and aneurysm screening. Further details can be found by accessing the practice's website at www.uptondoctors.co.uk

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. There were systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff. There were records of safety checks and these were available in paper format and on the practice computer system. 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. All staff received up-to-date safeguarding and safety training appropriate to their role. Alerts were put on the computer system and staff demonstrated they understood their responsibilities and were aware of the lead GPs for safeguarding.
- The practice worked with other agencies to support patients. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Clinical staff kept a register of all patients that they considered to be at risk and regularly reviewed it. This was discussed at daily multi-disciplinary meetings with district nurses, social workers and in monthly clinical team meetings.
- 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).
- Staff who acted as chaperones were trained for the role and had received a DBS check. A notice was displayed in the waiting room advising patients of their right to have a chaperone.
- There was an effective system to manage infection prevention and control. The practice nurse was the infection prevention control lead and annual audits were carried out.
- 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.
- Records showed that all members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly by the pharmacist for the dispensary.

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. GPs provided cover where possible and other gaps were covered by a locum GP who was known to the practice.
- There was an effective induction system for temporary and permanent staff tailored to their role. For example, we saw new starter packs available for locums and registrars that included checks made against their registration status, qualifications and training records. An induction pack was available and included health and safety, information governance, safeguarding, infection control, appointment system and internal procedures.
- 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 such as sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, a dispensary manager going on maternity leave.
- The practice had a business continuity plan with up to date contact numbers. Copies were kept off site in the event of an emergency and there was remote access to an emergency computer.

Information to deliver safe care and treatment

Good

Are services safe?

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. These were reviewed in multi-disciplinary team meetings where appropriate.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, there was a system to share information with out-of-hours and secondary services.
- The lead nurse for older and complex patients had established a monitoring system to ensure patients discharged from hospital were reviewed within 24 hours. Work with the dispensary team ensured patients received the medicines prescribed.
- Referral letters included all of the necessary information.
- The practice used a directory of local guidelines to facilitate referrals through pathways. This provided comprehensive, evidence based local guidance and clinical decision support at the point of care and was effective in reducing referrals.

Safe and appropriate use of medicines

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

- The systems for managing medicines were monitored by the practice pharmacist, including vaccines, medical gases, emergency medicines and equipment. The practice kept prescription stationery securely and monitored its use. Staff prescribed, administered and supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Emergency medicines were held at the practice and anticipatory medicines were taken on home visits. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- 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.
- Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw evidence of review of these procedures in response to incidents or changes to guidance in addition to annual review.
- Arrangements for dispensing medicines at the practice kept patients safe. The practice had signed up to the Dispensing Service Quality Scheme (DSQS), which rewards practices for providing high quality dispensary services to patients.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues, including health and safety, service continuity, flood plan, fire and legionella.
- There was a health and safety lead in place who had training specific to their role.
- The practice monitored and reviewed activity via regular meetings, risk assessments, clinical and non-clinical audits. 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 comprehensive system and procedure for recording and acting on significant events and incidents. A process of root cause analysis was used to investigate incidents and events which identified factors and supported staff in taking corrective action. Staff understood their duty to raise concerns and report

Good

Are services safe?

incidents and near misses. Most staff were able to share with us an example of a significant event, the action taken and learning shared. Leaders and manager supported them when they did so.

- There were effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons at practice meetings and with another practice to identify themes and improve the safety to patients. Incidents were logged efficiently and then reviewed promptly. The practice had recorded 55 significant events in the past 12 months. For example, the incorrect notes were booked on the appointment system for a patient. Ways of minimising the risk was discussed with staff and the three point check when booking in patients was revisited.
- There was an effective system in place led by the dispensary team for receiving and acting on safety alerts. A dispensary team member received the safety alerts and passed them on to the relevant member of staff. When alerts concerned medicines the relevant clinician or the pharmacist carried out patient searches to determine whether there were any potential risks to patients. The practice learned from external safety events as well as patient and medicine safety alerts.
- We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

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.
- Systems ensured all clinical staff were kept up to date. Staff told us they could access guidelines from The National Institute for Health and Care Excellence (NICE) electronically, and that this information was used to deliver care and treatment appropriate to patients' needs.
- GPs attended local education events to improve practice in relation to new guidance and standards.
- The practice was prescribing hypnotics, antibacterial prescription items and antibiotic items including Cephalosporins and Quinolones in line with local and national averages.
- 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.
- The practice worked collaboratively with another local practice to deliver improved services for patients. For example, dermatology care and peer led reviews.

Older people:

- Older patients who were frail or may be vulnerable received a full holistic assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medicines using the electronic frailty index to co-ordinate support packages and interventions.
- The practice appointed a nurse as the lead for older people's services. Home visits were carried out and coordinated with specialist services. Referrals were made to voluntary services and supported by an appropriate care plan that was reviewed at monthly clinical meetings.
- Patients aged over 75 were invited for a health check. If necessary, they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training including diabetes and respiratory care.
- 99% of patients diagnosed with atrial fibrillation (a heart condition) were treated with anti-coagulation drug therapy; this was higher than the local average of 94% and the national average of 88%. The practice exception rate was 11% which was comparable to the local average.

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.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- Quarterly safeguarding meetings were held with the lead GP to monitor all looked after children and those at risk of harm.

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

Good

Are services effective?

(for example, treatment is effective)

- The practice's uptake for cervical screening was 80%, which was in line with the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have appropriate vaccines.
- 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. In the last year the practice had offered 363 health checks and 228 had been completed.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including patients affected by substance misuse and those with a learning disability. The practice participated in the substance misuse shared care programme and a counsellor attended the practice weekly.
- The nurse practitioner visited patients discharged from secondary care to ensure all services were in place and that medicines were reconciled.

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

- 85% of patients diagnosed with dementia had there care reviewed in a face to face meeting in the previous 12 months. This was comparable with the Clinical Commissioning Group (CCG) of 84% and the national average of 83%.
- 90% of patients diagnosed with schizophrenia, bipolar disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to 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, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 93% compared with the CCG average of 93% and the national average of 90%. The percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation was 98% compared with the CCG average of 96% and the national average 95%.

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 undertook regular clinical audits and actions and improvements were implemented to enhance the quality of care. The practice provided evidence of a number of multiple cycle audits where actions had been implemented and improvements monitored. In one particular example we looked at an audit of the number of patients in care homes with a completed do not attempt cardiopulmonary resuscitation (DNAR) form in place; the audit highlighted missing information. The practice worked with the nursing homes to ensure additional information was added to the forms on admission.

The most recent published Quality Outcome Framework (QOF) results were 100% of the total number of points available compared with the (CCG) average of 99% and the national average of 96%. (QOF is a system intended to improve the quality of general practice and reward good practice). The overall exception reporting rate was 5% compared with the national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients declined or did not respond to invitations to attend a review of their condition or when a medicine was not appropriate.)

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings,

appraisals, 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. The nurse practitioners received regular support and supervision from the GPs.

- Staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to e-learning training modules and face-to-face training.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Upton Surgery was a training practice with GP trainees, junior doctors and medical students from Warwick University.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment. The practice held daily multi-disciplinary meetings with social workers and district nurses to co-ordinate home visits using the gold traffic light system for risk management.

- 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. This included working with social workers, health visitors and district nurses.
- 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 participated in the local prescribing shared care scheme and saw patients who were affected by substance misuse weekly.
- 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 receiving end of life care, 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. Patients responded positively when asked about the practice promoting healthy lifestyles.
- 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, 8% of patients were offered smoking cessation and 5% had stopped smoking.
- The practice worked closely with the early dementia intervention service and Age UK to provide a range of advice for patients such as money and legal, health and wellbeing, care and support.
- The practice offered fitness for life exercise classes and promoted healthy living to support national initiatives. For example, The Falls Prevention Programme to reduce hospital admissions and improve balance. The practice had received positive feedback from patients who had benefitted from the service.

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. Comments included that the staff were friendly and helpful and always listened to concerns. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the annual National GP Patient Survey, published in July 2017, showed patients felt they were treated with compassion, dignity and respect. 219 surveys were sent out and 134 were returned. This represented about 1.22% of the practice population. The practice was above average or in line with the local and average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients who responded said the GP was good at listening to them compared with the Clinical Commissioning Group (CCG) average of 92% and the national average of 89%.
- 94% of patients who responded said the GP gave them enough time compared with the CCG average of 90% and the national average of 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 97% and the national average of 95%.
- 93% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 89% and the national average of 86%.
- 94% of patients who responded said the nurse was good at listening to them compared with the CCG average of 94% and the national average of 91%.
- 95% of patients who responded said the nurse gave them enough time compared with the CCG average of 95% and the national average of 92%.
- 95% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 94% and the national average of 91%.
- 95% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 87% and the national average of 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and took action to ensure they met 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. Information was also available in alternative languages on the practice website.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials. We saw notices in the reception area advising patients that information was available in alternative formats. The practice had held a sensory impairment information day.
- Practice staff had completed customer care and care navigation training.
- The practice identified patients with caring responsibilities, so they could provide advice and support when needed.

Good

Are services caring?

- The practice computer system alerted clinical staff if a patient was also a carer and offered flu vaccinations.
- Staff helped patients and their carers find further information and access community and advocacy services such as Age UK, pilates and walking groups.
- The practice had identified 175 patients as carers (approximately 1.6% of the practice list).
- Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation or a home visit at a flexible time 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 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:

- 90% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 83% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 89% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice and population groups for older people, people with long term conditions, families, children and young people and people whose circumstances makes them vulnerable as outstanding. We rated working age people and people experiencing poor mental health including people with dementia) as good for providing responsive services.

The practice was rated as outstanding for providing responsive services because:

- The practice had appointed a nurse as the lead in older patient and complex care. This had a positive impact on reducing hospital admissions. The nurse would complete clinical triaging, hold daily multi-disciplinary meetings with social workers and district nurses, complete home visits, coordinate care with local services, complete medicine reviews, holistic assessment and advanced care planning. Interventions and risk management plans supported patients to remain in their homes. In a three month period from November 2017 until January 2018, 162 hospital admissions were avoided.
- The practice offered support to frail, elderly and vulnerable adults with complex needs to identify risk and deliver care closer to home. The nurse for older patients would coordinate appointments, prescriptions and care for patients who found it difficult to attend appointments or who had difficulty in accessing online appointments or services. This was supported by referrals to local services for support and assistance.
- Patients aged 90 years or more and their carers could access a dedicated line for direct access and support.
- The practice worked as part of the Pro-Active Care Team (PACT) in partnership with the Worcestershire Health and Care NHS Trust and the local GP Federation. This team cared specifically for those patients who were on the unplanned admissions register to avoid further unplanned admissions to hospital. The practice held daily multi-disciplinary meetings with social workers and district nurses to co-ordinate home visits using the gold traffic light system for risk management. Detailed care plans were produced and discussed in monthly clinical meetings to monitor progress.
- The practice achieved high GP patient survey results relating to access and reviewed and acted on these results. The practice understood the rurality of its patients and had strong links with Upton community care that provided volunteer drivers to assist vulnerable patients attending appointments to the practice. This made appointments more accessible to vulnerable and frail patients. In 2017, 785 patients used the transport service to attend appointments at the practice.
- The area of Upton is nine miles away from the nearest NHS facility so the practice offered minor injury and minor surgery clinics for conditions such as burns, dislocations, bites and cryotherapy.
- Consultation appointments with GPs could be extended to discuss complex concerns.
- Medicines could be delivered to patients homes and health checks could be carried out on home visits. For example, the pharmacist completed domiciliary visits to patients' homes to discuss their medicines and equipment.
- The patient participation group (PPG) supported events such as the walking groups, gave presentations in local schools on health promotion and supported 'The Big Get Together' event to raise awareness of community services.
- Practice staff had initiated fitness classes in line with The Fall Prevention initiative. The outcomes from the initiative included an increase in patient confidence to self-manage because the risk of future falls had been reduced.

Responding to and meeting people's needs

The practice was proactive in their approach to understanding the needs and preferences of different groups of people. Services took account of patient needs and preferences and were delivered in a way that ensured flexibility and choice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 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 reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.
- The practice used events to engage with the local community and promote patients' healthcare and self management.
- Appointments were available outside of core business hours. For example, Saturday mornings to meet the needs of working people, families and children.
- There were longer appointments available for patients with a learning disability or those experiencing poor mental health.
- Same day appointments were available for children and those patients with complex needs, even if sessions were fully booked.
- There were facilities for patients with disabilities and translation services were available.
- The practice offered cognitive behavioural therapy sessions and private counselling services.
- There were nurse run anticoagulation clinics at the practice.
- The practice offered aneurysm screening, retinal screening, chiropody, podiatry and audiology services. Some services were provided by clinical staff in the practice, whilst others were coordinated with other healthcare professionals.
- Regular meetings took place to discuss and plan care for vulnerable patients and those with complex needs.
- Practice staff offered proactive, personalised care to meet the needs of older patients. They offered home visits and urgent appointments for those with enhanced needs. The GP, practice nurse and pharmacist also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice worked closely with local schools and colleges to offer work experience placements and apprenticeship programmes to students interested in healthcare as a potential career.
- The practice offered appointments to children under 16 years of age to discuss topics such as bullying, exam related stress, contraception, relationships and weight. GPs from the practice regularly attended the Sure Start programme to deliver presentations to parents about the management of respiratory tract infections such as coughs and colds. They also provided resources on health related issues to primary schools. The practice worked closely with school nurses and services to refer young children who suffered from rural isolation.
- The practice worked closely with local primary schools to deliver presentations and resources during September on health information such as respiratory tract infections, earaches, coughs and colds.
- The practice held weekly clinics from Age UK to provide support services for older patients such as social prescribing.
- To promote health and wellbeing the practice ensured appropriate patients were encouraged to participate in wellbeing services such as strength and balance classes, pilates and walking groups. The classes were available each week in the practice and 24 patients attended the strength and balance class every week.
- The practice developed and funded the 'Fitness for Life' exercise classes which were run weekly and were designed to build confidence and independence.
- The practice offered educational study days to patients and healthcare workers such as spirometry workshops, NHS diabetes prevention programme, childhood immunisations, contraception and sexually transmitted infections (STI's).
- The practice contacted patients following an emergency admission to hospital within 24 hours after discharge for continuity of care.
- The facilities and premises were appropriate for the services delivered.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with multi-disciplinary teams.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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.
- Each care home had an allocated GP who maintained regular contact and completed weekly visits and ward rounds.
- The practice held up to date registers of patients' health conditions and information was held to alert staff if a patient had complex needs.
- The practice held a 'frailty' register and these patients were identified by the practice and offered extra support. For example, the lead nurse for older patients completed home visits to coordinate services and packages of care with other services.
- Patients aged 90 years or more and their carers could access a dedicated line for direct access and support to the practice.
- The nurse for older patients and complex care monitored patients who were assessed as high risk. Detailed care plans were produced with multidisciplinary teams to avoid hospital admissions.
- Extended appointments were available to ensure all aspects of their needs were assessed.
- The practice supported frail patients by ordering and dispensing their medicines into weekly dosage packs and delivering this to their homes.
- Older patients were offered annual health checks and where necessary, care, treatment and support arrangements were implemented.
- Practice staff worked with other agencies to provide patient support. For example, weekly sessions were held at the practice by Age UK.
- Older patients were encouraged to participate in strength and balance classes, pilates and walking groups. The classes were available each week in the practice and 24 patients attended the strength and balance class every week. On completion patients were offered the 'Fitness for Life' exercise programme designed to build confidence and independence.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. For example, an accredited practice nurse who specialised in diabetes held regular education sessions for these patients.
- The practice provided information leaflets for advice and support for long term conditions. There was detailed information on diabetes, respiratory, heart disease and other conditions. The website gave information about the clinics available and local and national support groups.

  Longer appointments and home visits were available when needed.

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 practice had information on the website for expectant and new mothers. This covered topics such as contraception, pregnancy and labour, you and your baby.
- The practice built links with local schools. It ran an art project with students and promoted various healthcare topics to promote the types of services available for this age group such as bullying, exam related stress and contraception.
- The practice had recruited students to be part of the Patient Participation Group (PPG).

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

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.
- Telephone consultations and triaging were available which supported patients who were unable to attend the practice during normal working hours.
- The practice offered lunchtime appointments for those people who were able to attend during lunch breaks.
- The practice offered annual aneurysm screening for patients during November and December.
- Online services were available for booking appointments and ordering repeat prescriptions.
- The practice website gave advice to patients about how to treat minor ailments without the need to be seen by a GP.
- Clinical data told us that breast screening and bowel cancer testing results were in line with local and national averages.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including, substance misusers, those with a learning disability and those with dementia.
- There was a clinical lead for managing the care of vulnerable adults and children.
- The GP who specialised in the care of patients who had a learning disability carried out their annual health reviews with an extended appointment time.
- The practice was proactive in understanding the needs of the patients, such as people who may be approaching the end of their life and people who may have complex needs, such as housebound patients. The practice followed the Gold Standards Framework (GSF) for end of life care which was evidence based guidelines to deliver high quality end of care life. Each patient was assessed according to their needs of support.
- Patients who were frail or deteriorating would be offered home visits to coordinate packages of support and medicines were delivered to their home.
- The practice had recognised that patients with complex conditions had poorer outcomes. In order to try and address this the practice employed a complex care team to provide interventions to patients to avoid unplanned hospital admissions. For example, in a three month period from November 2017 until January 2018, 162 hospital admissions were avoided.
- The dispensary piloted a project identifying 378 vulnerable patients over the age of 65 who may have problems taking their medicines correctly. In these cases the practice wrote to patients to offer a monitored dosage system. 23 patients converted to dosette systems.
- There were monthly meetings held to discuss the care and treatment of vulnerable patients. The practice worked closely with multi-disciplinary teams in the building such as the social work and district nurse team to deliver enhanced care plans.
- The practice worked collaboratively with the substance misuse service and offered weekly sessions to ensure their patients benefitted from this service.

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

- There were named GP leads for mental health, depression and dementia. Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice worked closely with multi-disciplinary teams in the case management of patients who experienced poor mental health, including those with dementia.
- GPs carried out assessments of patients who experienced memory loss in order to capture early diagnosis of dementia. This enabled staff to put a care package in place that provided health and social care support systems to promote patients wellbeing.

Timely access to the service

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. Patients spoken with on the day of inspection reported that appointments ran on time.
- Patients with the most urgent needs had their care and treatment prioritised.

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 comment cards.

- 84% of patients who responded were satisfied with the practice's opening hours compared with the Clinical Commissioning Group (CCG) average of 78% and the national average of 76%.
- 98% of patients who responded said they could get through easily to the practice by telephone compared with the CCG average of 73% and the national average of 71%.
- 91% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 87% and the national average of 84%.
- 92% of patients who responded said their last appointment was convenient compared with the CCG average of 85% and the national average of 81%.
- 97% of patients who responded described their experience of making an appointment as good compared with the CCG average of 88% and the national average of 85%.
- 82% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Forty complaints were received in the last year. We reviewed these complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. Complaints were discussed at practice meetings and learning from these resulted in improvements to the quality of care. For example, a complaint from a patient who was unhappy about the delay in treatment following a diagnosis from the hospital. This had been investigated by the practice and processes had been followed. This was discussed in team meetings and ideas shared on ways to improve communication and processes.
- Staff handled complaints in a timely manner and had initiatives to seek patient feedback in various forms such as a comment box.

Are services well-led?

Outstanding ☆

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

Our findings

We rated the practice as outstanding for providing a well-led service.

The practice was rated as outstanding for well-led services because:

- There was compassionate, inclusive and effective leadership throughout the practice. Staff were proud to work for the practice and put the needs of the patient first. The practice had received a number of awards for its commitment to patient care.
- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- The leadership, governance and culture were used to drive continuous improvements to respond to the needs of patients and improve the delivery of high quality patient centred care.
- The practice understood the needs of its population and was actively involved in the community and tried wherever possible to seek out opportunities to promote good self-healthcare.
- The practice was responsive in recognising areas of improvement for patients by actively reviewing and implementing care to meet the needs of its population. For example, dermatology clinic, minor op's clinic, domicilliary home visits and an older population nurse to coordinate care for older, frail and vulnerable patients.
- The practice had a track record of developing and encouraging its staff. For example, the practice had funded a nurse to complete a course to enhance the work of older patients.
- There were high levels of satisfaction, with very low turnover. Staff were proud to work at the practice and spoke highly of the open culture.
- The practice had written a three year strategy dated 2016-2019 and held strategy meetings every six months. The purpose of the meetings was to improve patient access, further develop care for frail patients, peer review referrals to reduce the numbers of referrals made and build on areas of improvement.
- Communication with staff was comprehensive. Management had full oversight of the performance of the practice and used this to drive positive change. Management actively promoted training and development opportunities and was keen to build links with local schools and offer apprenticeship programmes. Regular meetings were held with staff and patients to engage them in levels of decision making. Positive feedback from patients was regularly communicated to staff members. The practice had monthly newsletters for staff and patients on developments in the practice and to promote health campaigns.

Leadership capacity and capability

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

- There was clear, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver sustainable care. The GPs were supported by a management team. There were deeply embedded systems of leadership which aimed to ensure that senior staff had considered the needs for the future.
- 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. Challenges included the high older population, rural location and increase in patient demand.
- The practice was forward thinking and innovative in its approach to providing patient centred care. It actively sought opportunities to engage with patients and develop new services. For example, collaborative working with another practice to deliver dermatology services.
- 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. The practice took steps to ensure succession planning was in place and regularly reviewed it.

Are services well-led?

Outstanding ☆

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

- A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. For example, multidisciplinary working across health and social care services to provide better outcomes and reduce hospital admissions for frail, vulnerable and the older population.
- The practice leadership was committed to meeting the needs of its population and sought out opportunities to provide responsive joined up services to provide better outcomes for patients.

Vision and strategy

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

- The practice developed staff roles considered to be beneficial to its practice population and the development was incorporated into its 2016 strategy plan. This was reviewed in practice meetings and six monthly strategy meetings.
- The practice understood the rurality and challenges of its practice population and developed a strategy to build responsive services in line with health and social care priorities across the region. There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Strategies and plans were aligned in the wider health economy and there was a demonstrated commitment to a system wide collaboration and leadership.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. The practice regularly engaged with patients and the community to promote the services available to patients in the practice.
- The vision was to provide a consistent offer of high quality, patient centred services with a caring approach to every individual.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. They were motivated to achieve the vision and were dedicated to the care of the patients.
- The practice built stronger future collaborative work with neighbouring practices to build a stronger future and share best practice. The collaboration of a dermatology clinic across two practices enhanced patient care and promoted good access.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were consistently implemented, and had a positive impact on the quality and sustainability of services. The practice planned its services to meet the needs of the practice population.

Culture

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

- Staff stated they felt respected, supported and valued. There were high levels of satisfaction across all staff groups, demonstrated by a low staff turnover for many years. They were proud to work in the practice.
- The practice focused on the needs of patients and worked to initiate and deliver innovative holistic approaches to improving the wellbeing of their patients. For example, the walking group had initiated and continued to develop further. The practice also ran weekly pilates and strength and balance classes. They had strong links with community organisations such as Upton community care who provided transport for patients to appointments and Age UK who attended weekly.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. Staff knew the vision and values of the practice and adopted this in their work.
- 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 and feedback from these concerns were discussed at

Are services well-led?

Outstanding ☆

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

meetings. There was evidence of a strong collaboration, team working and support across all functions and a common focus on improving the quality and sustainability of care.

- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. The practice had supported staff with time off for professional development. For example, a nurse had completed the older people's nursing fellowship programme.
- 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 with programmes of staff meetings and communication. For example, a monthly staff newsletter.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.

- 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 those relating to safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. These were easily accessible to all staff.
- There were regular team meetings to update staff on any governance changes.

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.
- There was a suite of risk assessments and action plans that were monitored and acted upon to ensure the safety of staff and patients.
- 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 safety alerts, incidents, and complaints. There was a demonstrated commitment to best practice performance and risk management systems and processes.
- 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 on how to respond to major incidents. For example, the use of a generator in the event of a power cut.
- The practice implemented service developments to understand the 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.

Are services well-led?

Outstanding ☆

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

- 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 also used information from NHS England and the Clinical Commissioning Group (CCG) to monitor performance and make improvements.
- 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 and was proactive in identifying any gaps to improve performance.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- The practice had regular meetings to feedback to staff compliments received from patients about the quality of care.
- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted upon to shape services and culture. For example, the practice ran an art project with a local school and had recruited students to be part of the patient Participation Group (PPG).
- There was an active PPG. The group met quarterly with the practice and was involved in many community projects. We spoke with members of the PPG on the day of the inspection who told us that the practice listened to them. The PPG worked in partnership with a local school to offer work experience placements and supported the art group. The PPG had assisted in health presentations in schools and was instrumental in the practice newsletter and reviewing complaints procedures.
- The practice engaged proactively with the community and held regular information sessions and fundraising events. For example, the practice held 'The Big Get Together' event during November 2017 to promote support services in the community and provide information on health promotion. Patients at risk of social isolation were able to benefit by meeting other people and learning about services available in the area.
- The service was transparent, collaborative and open with stakeholders about performance. Feedback from external stakeholders was positive about the practice performance and engagement.

Continuous improvement and innovation

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

- There was a strong focus on continuous learning and improvement at all levels within the practice, this included root analysis of significant events, learning and improvements through complaints and responding to data in relation to prescribing and best practice.
- The practice team was forward thinking to improve the outcomes for patients in the area. For example the pilot of a dispensary project to identify patients who need support to manage medicines safely.
- There was a clear approach to seeking out and integrating services to improve patient care. For example, accessible services in the practice which offered a 'one stop' shop and a holistic approach to patient care.
- The practice made use of internal and external reviews of incidents such as significant events by sharing this with another practice to identify themes and trends to improve its delivery.
- The practice held regular health education sessions to staff and patients. For example, sepsis training from a local hospital.