Westbury Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Westbury Medical Centre on 28 September 2016. Overall the practice is rated as Good.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For instance, the practice had undertaken a detailed study of GP appointment demand and had put in place an action plan which had released over 400 GP appointments over a six month period and improved the range of appointment options available to patients who needed extra support. This learning had been shared with members of the local CCG.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, the practice had worked with the patient group to present a series of patient education events.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw one area of outstanding practice :

The practice had established a fitness and body conditioning club for patients with, or at risk of developing, long term health conditions and patients experiencing poor mental health. The club had an active membership of over 50 patients and we saw evidence of improved outcomes for patients including evidence of

Summary of findings

controlled weight loss, improved blood sugar levels and managed reductions in medicines taken. We looked at records of eleven patients who attended the weekly classes and saw that blood sugar levels had reduced by 10% for four patients with diabetes, three patients had managed to reduce or stop certain medicines and three had achieved their targets for weight loss.

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

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- Health care assistants had been trained to undertake chronic disease management roles and did this using structured management tools which ensured that patients were referred to a GP at predetermined intervals, when clinical decisions were required or when certain conditions were met.
- Data showed that the practice was performing highly when compared to practices nationally. For instance, 85% of patients had well controlled blood sugar levels compared to a CCG average of 75% and a national average of 78%. The percentage of patients with diabetes who had had a recent foot examination was 94% (CCG average 85%, national average 88%). The exception reporting rate for diabetes was 9% (CCG average 11%, national average 11%).
- The practice had recruited a qualified Physician Associate to support doctors in the diagnosis and management of patients. This included taking medical histories, performing examinations, analysing test results, and diagnosing illnesses under the direct supervision of a doctor. GP partners had

Summary of findings

written a bespoke, practice specific, training manual and standard operating procedures which were consistent with General Medical Council guidance on appropriate delegation and these were used to manage and supervise this new role.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For instance, the practice had undertaken a detailed study of GP appointment demand and had put in place an action plan which had released over 400 GP appointments over a six month period. This had been shared with members of the local CCG who had asked for a formal presentation to be given to other practices.
- The practice had established a fitness and body conditioning club for patients and held weekly exercise classes with a fitness instructor. This was primarily intended to support patients with, or at risk of developing, long term health conditions and patients experiencing poor mental health but patients at risk of becoming socially isolated were also encouraged to join. The average attendance at classes was between 40 and 50 patients every week. We saw evidence of improved outcomes for patients including evidence of controlled weight loss, improved blood sugar levels and managed reductions in medicines taken.
- Walk-in appointments with advanced nurse practitioners were available from 8:00am every week day.
- A member of the reception team had been given a lead role in identifying and supporting homeless patients and patients whose living accommodation consisted of a series of informal and insecure temporary arrangements with friends and family.

Summary of findings

The practice recognised the risks posed by this chaotic lifestyle and allowed these patients to register using temporary addresses or the practice address and mobile telephone number. The practice told us that the number of patients included fluctuated frequently but could be up to ten patients at any one time.

- Patients could access appointments and services in a way and at a time that suited them. Patients could book or cancel appointments online and could receive text message reminders about appointments, vaccinations and immunisations. Patients could also use the practice website to-self refer into the local physiotherapy service.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- The practice website included an extensive self-help section to support patients in managing their own day to day health. For instance, there was advice on what to keep in a domestic first aid kit and medicine box, there was information about maintaining good eyesight and dental hygiene, as well as a wide range of links to local and national health resources.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led.

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had responded to industry wide recruitment difficulties by adopting an innovative staff mix strategy. For instance, the practice had recruited a Physician Associate and had created and recruited to a specialist administrative role whose responsibilities included reviewing all incoming correspondence, including hospital discharge letters and pathology results. These staff provided support for GPs and meant that the practice was able to increase the number of GP appointments available to patients.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.

Summary of findings

- The practice undertook regular reviews to audit staff knowledge and compliance with practice procedures. GP partners had designed role specific question and answer sessions and quizzes to do this and staff we spoke with told us they found this very useful.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients using new technology, and it had a very engaged patient participation group which influenced practice development. For instance, the practice undertook patient surveys used an SMS message based system and had worked with the PPG to hold patient education events.

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

The practice is rated as good for the care of older people.

- The practice had provided the ambulance service and accident and emergency department (A&E) at a local hospital with a special number to by-pass the practice telephone switchboard. Ambulance and A&E staff used this to alert the practice when contact with a patient indicated that the patient would benefit from a GP visit.
- GPs used a risk stratification tool designed to identify patients at highest risk of attending A&E or being admitted to hospital and had identified 2% of the practice population at most risk. The care of these patients was reviewed during weekly clinical meetings. The practice had a lower number of emergency admissions compared to local and national averages.
- Discharge letters for patients who had been in hospital were reviewed by a specialist administrator within one day of receipt and patients whose discharge notes indicated that follow up actions were required were prioritised and passed to GPs on the same day.
- Outcomes for conditions often associated with older people were better than local and national averages. For instance, 90% of patients diagnosed with hypertension had well controlled blood pressure compared to the CCG average of 81% and national average of 84%. The exception reporting rate for this domain was 3% (CCG average 5%, national average 4%).

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions.

- Patients diagnosed with chronic obstructive pulmonary disease (COPD) were provided with a 'Hospital Admission Avoidance Pack' and had been instructed in the correct use of its contents.
- The practice had established a fitness and body conditioning club to support patients with, or at risk of developing, long term health conditions and patients experiencing poor mental health. The club provided weekly fitness classes under the instruction of a qualified fitness instructor and had over 50 active members. The practice could demonstrate improved outcomes for patients including evidence of controlled weight loss, improved blood sugar levels and managed reductions in medicines taken.

Summary of findings

- Nursing staff had lead roles in chronic disease management. Health care assistants had also been trained to undertake chronic disease management and this had improved the range of appointments available to patients.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Parents or carers who wished to opt out of the primary immunisation programme were invited to attend a face-to-face meeting with a GP and patients who failed to attend for immunisations were contacted by letter, text message and telephone.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 88%, which was higher than the CCG average of 80% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Appointments were available outside of normal working hours. The practice held two late evening clinics when appointments with GPs and nurses were available and provided walk-in appointments with Advanced Nurse Practitioners from 8:00am every weekday.
- Telephone and email consultations were available for patients who were unable to attend the practice.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people who circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patients whose living arrangements did not fit the traditional description of homelessness but who accommodation was insecure or chaotic could register using temporary addresses or using the practice address.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Care planning for patients with learning difficulties was undertaken using a nationally recognised tool.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- Performance for mental health related indicators was better than local and national averages. For example, 99% of patients

with schizophrenia, bipolar affective disorder and other psychoses had an agreed documented care plan on the record (CCG average 88%, national average 88%). The exception reporting rate this indicator was 6% (CCG average 7%, national average 13%).

- 84% of patients diagnosed with dementia had had their care reviewed in a face-to-face review in the preceding 12 months (CCG average 86%, national average 84%). The exception reporting rate for this indicator was 0% (CCG average 6%, national average 8%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Three hundred and thirty five survey forms were distributed and 112 were returned. This represented 1% of the practice's patient list.

- 72% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 78% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 83% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 81% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 comment cards which were all positive about the standard of care received. Patients said they found staff to be helpful and pleasant and doctors and nurses to be compassionate and caring.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Westbury Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser.

Background to Westbury Medical Centre

Westbury Medical Centre provides GP primary care services to approximately 10,500 people living in Tottenham and Wood Green, London Borough of Haringey. The practice has a Personal Medical Services (PMS) contract for providing general practice services to the local population. Personal Medical Services (PMS) agreements are locally agreed contracts between NHS England and a GP practice. The practice is a teaching practice for medical students.

There are currently two male GP partners, both of whom are full time. There are two part time female salaried GPs. The practice provides a total of 30 GP sessions per week.

The clinical team is completed by two advanced nurse practitioners who work full time, two long term locum practice nurses who work part time and three health care assistants, two of whom are also trained as phlebotomists (Phlebotomists are specialist healthcare assistants who take blood samples from patients for testing in laboratories).

There is also a practice manager, five administrative and five reception staff. The practice is registered with the Care Quality Commission to provide the regulated activities of maternity and midwifery services, surgical procedures, treatment of disease, disorder or injury, diagnostic and screening procedures and family planning.

Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the very highest levels of deprivation and level ten the lowest. This information also shows that Income Deprivation Affecting Older People (IDAOPI) is 38% and is higher than the CCG average of 32% and the national average of 16%. Income Deprivation Affecting Children (IDACI) is 35% (CCG average 29%, national average 20%).

The practice is located in a three storey former residential building. Consulting rooms are located on two floors. Patients unable to access the second floor are accommodated on the ground floor.

The practice opening hours are 8:00am to 6.30pm on Mondays, Thursdays and Fridays and 8:00am to 8:00pm on Tuesdays and Wednesdays. The practice is closed on Saturdays and Sundays. Telephones are answered between 8:00am and 6:30pm daily.

Patients can book appointments in person, on-line or by telephone. Patients can access a range of appointments with the GPs and nurses. Face to face appointments are available on the day and are also bookable up to four weeks in advance. Telephone consultations are offered where advice and prescriptions, if appropriate, can be issued and a telephone triage system is in operation where a patient's condition is assessed and clinical advice given. Home visits are offered to patients whose condition means they cannot visit the practice.

The practice has opted to provide out of hours services (OOH) to patients and these were provided on the practice's behalf by a nominated provider. The details of

the how to access the OOH service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website.

The practice provides a wide range of services including clinics for diabetes, weight control, asthma, contraception and child health care and also provides a travel vaccination clinic. The practice also provides health promotion services including a flu vaccination programme and cervical screening.

The practice had not previously been inspected.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 September 2016. During our visit we:

- Spoke with a range of staff including two GPs, a physician associate, a nurse practitioner, practice manager, health care assistants and members of the administration and reception teams and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we saw a record of an occasion when a patient had been administered a vaccination by a clinician who was unaware that the patient had already received the vaccination from another clinician at the practice. The incident was reviewed at a practice meeting and staff received advice and training about booking vaccination appointments for patients. The patient was informed about the error and received a written explanation and apology.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs did not always attend safeguarding meetings in person but always provided reports where necessary for other agencies. The practice had a dedicated email address for child protection requests and this had been shared with the local safeguarding team. This email account was created to ensure that messages regarding child safeguarding matters could be identified and actioned immediately and was monitored daily. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice manager were trained to child protection or child safeguarding level 3, nurses were trained to level 2, healthcare assistants and non-clinical staff were trained to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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). When a clinician asked a patient if a chaperone was required, the patient's response was recorded on the consultation notes. When a chaperone attended a consultation, the name of the chaperone was also recorded.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken although these did not include an action plan to remedy any concerns. For instance, the audit had identified that sinks in consulting rooms had overflows and taps were not of the elbow operated design. However, the practice told us that funding had been secured to replace these items but plans to do so had been postponed whilst a proposal to relocate the practice to a new premises was being considered.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).

Good

Are services safe?

Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction (PSD) from a prescriber. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. There was also a record of the Hepatitis B immunisation status for clinical staff.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. The practice did not have a risk assessment for legionella. The practice had contacted an approved contractor and booked a risk assessment visit immediately after we pointed this out to them. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- 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 and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and other key contacts including the practice's out of hours provider.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We saw an example of a Public Safety Alert (PSA) which was issued by NHS England in March 2016, following a patient safety incident relating to the lack of prioritisation of GP home visits. The practice management team had discussed the alert in a clinical meeting and had revised and updated the practice Home Visit Procedure to include the guidance provided in the PSA. The practice told us this had helped improve the consistency and safety of the home visiting service, had made communication with patients more effective and had helped GPs to manage their workload.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice management team had identified that it had a lower than expected reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD) and Coronary Heart Disease (CHD) and had undertaken a review of underlying reasons. The review had found that although the relatively low average age of the practice population contributed significantly to the lower than expected rates, there were areas where improvements in clinical coding could be made. A search of patient records identified all patients who used certain medicines prescribed to manage COPD and CHD but not all of these patients had been coded appropriately. The practice had updated these records and had introduced an extra step into the clinical correspondence review process which meant that whenever the practice received incoming correspondence which referred to COPD or CHD conditions, a patient's record was checked to ensure that coding was accurate. This meant that historical inaccuracies were corrected and reduced the risk of mis-coding patients who developed these conditions in the future. (Chronic Obstructive Pulmonary Disease is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. Coronary Heart Disease is the term that describes when the heart's blood supply is blocked or interrupted by a build-up of fatty substances in the coronary arteries).

Management, monitoring and improving outcomes for people

Staff, teams and services worked collaboratively to ensure people who had complex needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined-up care to people who use services. All staff were actively engaged in activities to monitor and improve quality and outcomes. For instance, reception staff had received training in dementia awareness and learning disabilities awareness and used this to identify patients who might need extra support. Health care assistants had received training in mental health

health screening and how to identify early warning signals for conditions such as diabetes and coronary heart disease and would call GPs if they were concerned that a patient might be developing symptoms of a condition.

Health care assistants had been trained to undertake chronic disease management roles and did this using structured management tools which had been designed by GPs at the practice. These management tools ensured that staff followed appropriate clinical boundaries and included flowcharts which directed staff to refer patients to a GP at predetermined intervals, when clinical decisions were required or when certain conditions were met. The practice told us this had improved care for patients with long term conditions and we saw evidence that exception reporting rates were lower than local and national averages for all long term conditions. For instance, the exception reporting rate for chronic kidney disease was 3% compared the local average of 9% and national average of 8% whilst the exception reporting rate for asthma was 2% (CCG average 4%, national average 7%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data showed that the practice was performing highly when compared to practices nationally and outcomes for people

Good

Are services effective?

(for example, treatment is effective)

who use services were consistently better than expected when compared with other similar services. The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.8% of the total number of points available which was above the local CCG average of 91% and national average of 95%. Exception reporting rates were lower than CCG and national averages for all domains.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators was above local and national averages. For instance, 85% of patients had well controlled blood sugar levels compared to a CCG average of 75% and a national average of 78%. The percentage of patients with diabetes who had had a recent foot examination was 94% (CCG average 85%, national average 88%). The exception reporting rate for diabetes was 9% (CCG average 11%, national average 11%).
- Performance for mental health related indicators was above local and national averages. For example, 99% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed documented care plan on the record. The exception reporting rate this indicator was 6% (CCG average 7%, national average 13%).
- 84% of patients diagnosed with dementia had had their care reviewed in a face-to-face review in the preceding 12 months (CCG average 86%, national average 84%). The exception reporting rate for this indicator was 0% (CCG average 6%, national average 8%).

There was evidence of quality improvement including clinical audit.

- There had been five clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- The practice undertook annual mortality reviews and used these to identify where improvements to clinical care could be made. The most recent annual mortality report showed that the practice had reviewed each relevant record and had looked in particular, at diagnosis timescales and palliative care management as well as monitoring the quality of reports sent to the Coroners office. Learning from these reviews were shared with the clinical team.
- Findings were used by the practice to improve services. For instance, the practice had undertaken an audit of patients prescribed with Metformin (a medicine for the treatment of type 2 diabetes) who had a low glomerular filtration rate (Glomerular filtration rate (GFR) describes the flow rate of filtered fluid through the kidney). This medicine can cause lactic acidosis in some patients with a low GFR. At the first data collection point, the practice had identified patients with who had had low GFR recorded. Fifty per cent of these had had their treatment changed to an alternative which meant that 50% were still using Metformin. The practice created a code on the computer system which could identify patients whose latest recorded GFR was below 30. This caused an alert to be raised on the computer system so that the patient's condition was flagged to a GP for further review. The practice undertook a second audit six months later and found that a further six patients had had low GFR recorded. Of these 75% had been prescribed an alternative treatment indicating that the process for early identification of relevant patients had been improved.

Effective staffing

The continuing development of staff skills, competence and knowledge were recognised as

integral to ensuring high-quality care. Staff were proactively supported to acquire new

skills and share best practice. We saw that all staff were engaged to monitor and improve quality of care and outcomes for patients.

- GPs had completed extra training in dermatology, diabetes and substance misuse, following identification of high referral rates in these areas.
- Healthcare assistants had received extra training to undertake hypertension reviews, COPD/lung function reviews, spirometry clinics and smoking cessation clinics and were supported in these duties through supervision and an on-going education programme.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, nurses and health care assistants managing patients with long-term conditions had had recent update training in the management of asthma, type 2 diabetes and hypertension.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Nurse Practitioners had protected weekly clinical supervision meetings with a GP. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

The practice had identified a need to increase capacity within the clinical team but a campaign to recruit an additional GP to the practice had not been successful. A further review of the clinical skill mix had been undertaken, following which the practice had recruited a qualified Physician Associate to support doctors in the diagnosis and management of patients. The Physician Associate was trained to perform a number of roles including: taking medical histories, performing examinations, analysing test results, and diagnosing illnesses under the direct supervision of a doctor. GP partners had written a bespoke, practice specific training manual to manage the introduction of this new role. The practice put protocols in place to ensure the Physician Associate undertook duties which were consistent with General Medical Council guidance on appropriate delegation and which were in line with the Physician Associate's training and professional competence. Protocols included clearly defined clinical boundaries. The Physician Associate had been closely mentored by GPs and nurses during their induction and had on-going protected weekly supervision meetings with a GP. The Physician Associate provided 54 consultations per week. The practice had undertaken an early assessment of the impact of this new role and identified an increase in the number of GP appointments available to other patients and reduced waiting time for appointments although this had not yet been quantified.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- Annual reviews were provided for patients with learning disabilities, using a nationally recognised tool. The practice had developed its own detailed templates for patients being treated for substance misuse and patients with mental health conditions and used these during annual health reviews.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice had undertaken an in-depth GP Workload Audit and had identified that each GP was responsible for reviewing an average of approximately 60 items of correspondence per day. As a result of this review, the practice had created and recruited to a specialist administrative role whose responsibilities included reviewing all incoming correspondence, including hospital discharge letters and pathology results. This specialist administrator updated read codes and medicine changes on the computer system on a daily basis. The practice had created a protocol to ensure that all documents or test results that required GP action were forwarded to a GP on the day of receipt. This meant that GPs were able to more easily identify and carry out follow-up actions. The practice had undertaken a further audit of GP workload and identified that following the change, GPs were reviewing on average, 90% fewer documents every day. This

meant that GPs were able to spend more time attending to other duties, including providing extra appointment slots. The review also demonstrated that the accuracy of read codes in patient records had improved which meant that information available to clinicians and managers was more reliable and up to date.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

There was a consistent approach to support people to live healthier lives through targeted and proactive health promotion and prevention of ill-health, and every contact with people was used to do so.

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and people at risk of becoming homeless.
- Healthcare assistants were trained to provide support with cardiovascular disease prevention. The practice held a weekly smoking cessation clinic and patients could have one to one weight management appointments with a health care assistant.
- GPs used a risk stratification tool designed to identify patients at highest risk of attending A&E or being admitted to hospital and had identified 2% of the practice population at most risk. The care of these patients was reviewed during weekly clinical meetings. The practice had a lower number of emergency admissions compared to local and national averages.
- Patients diagnosed with chronic obstructive pulmonary disease (COPD) and asthma were provided with a 'Hospital Admission Avoidance Pack' and had been instructed in the correct use of its contents. The pack included supplies of medicines used to treat COPD and clear guidelines about when to use the pack and when to contact GPs for further support. The practice had audited the usage of avoidance packs by each patient in the twelve month period up to March 2016. This audit was used to identify patients who had used four or more packs in the twelve month period or two or more packs in any two month period. These patients had been contacted and invited to make appointments to have their conditions reviewed. (Chronic obstructive pulmonary disease is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease).
- The practice had provided the ambulance service and accident and emergency department (A&E) at a local hospital with a special number to by-pass the practice telephone switchboard. Ambulance and A&E staff used this to alert the practice when contact with a patient indicated that the patient would benefit from a GP visit.
- The practice had identified online video streaming as a potential platform to promote patient education in a way that was already familiar to a large proportion of the practice population and accessible to a majority of patients, including those who did not have English as a first language. In a pilot phase, the practice had produced a video which demonstrated a technique for managing a particular skin condition. This was available online to the public, but the practice had also actively promoted the video to patients with experience of managing skin conditions and had sought feedback from these patients.
- The practice had worked with the patient participation group to host patient education talks at the practice. A recent talk on minor illness management included presentations by a GP, a community pharmacists and a health care assistant and was attended by

Good

Are services effective?

(for example, treatment is effective)

approximately thirty patients. The practice had provided refreshments to encourage attendance and had sought feedback at the end of the event to assist in planning future events.

The practice's uptake for the cervical screening programme was 88%, which was higher than the CCG average of 80% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice could demonstrate that a failsafe system was in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Parents or carers who wished to opt out of the primary immunisation programme were invited to attend a face-to-face meeting with a GP and patients who failed to attend for immunisations were contacted by letter, text message and telephone.

Childhood immunisation rates for the vaccinations given were above the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94% to 98% (CCG averages 86% to 94%, national averages 73% to 96%) and five year olds from 81% to 99% (CCG averages 81% to 94%, national averages 81% to 95%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice subscribed to a music streaming service and played background music at a suitable volume in the waiting area. Staff told us this had improved confidentiality in the reception area. Patients we spoke with told us they felt the music had also made the atmosphere more pleasant.

All of the 27 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was average for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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. For example:

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 82% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpreter services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- The practice had used its understanding of its practice population to publish its own bespoke information leaflets. These were professionally printed in a high

quality format and provided information on a wide range of conditions and treatments that were relevant to the local community, written in easy read format and included details of support organisations available locally as well as nationally.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 125 patients as carers (approximately 1% of the practice list). Carers were invited to have flu vaccinations and information was available to direct carers to the various avenues of support available to them including information about funding for carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them or 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had a track record of sharing learning with other practices through the local CCG.

For example, in March 2015, the practice had undertaken a detailed study of GP appointment demand and had identified approximately 1% of the practice population (90 patients) who booked a disproportionately high number of GP appointments (appointments above a predefined number, booked over the preceding six month period). GPs reviewed patient records and consultation notes and had found that a significant percentage of the appointments booked by these patients could have been safely and effectively undertaken by properly trained and supervised nurses or health care assistants.

The practice had developed an action plan which involved training health care assistants to undertake chronic disease management roles. Clear written guidelines had been produced to ensure that staff had a solid understanding of individual roles and clinical boundaries and a process of supervision had been established.

The practice contacted patients whose care could be shared in this way and explained the new care pathway and encouraged them to book future appointments in this way when this was suitable. The practice could demonstrate how staff competence was regularly audited using supervision, appraisals, questionnaires and quizzes sheets. Staff involved in this programme told us they felt well supported and appreciated the regular opportunity to test their own knowledge.

The practice undertook a second study of GP appointment demand in July 2016 and found that the number of patients booking a disproportionately high number of appointments had fallen from approximately 1% to 0.3%, resulting in over 400 GP appointments being made available for other patients during the previous six months. Learning points from this study and the actions taken had been recorded and had been shared with the local CCG who had disseminated it to other practices. Some of these practices had since contacted the practice manager to ask for advice.

The practice provided access to a wide range of appointments and services that suited the needs of the practice population.

- There were extended opening hours on a Tuesday and Wednesday evenings until 8:00pm for patients who could not attend during normal opening hours.
- Walk-in appointments with advanced nurse pracitioners were available from 8:00am every week day. This meant that patients could have urgent access to highly trained clinicians with experience of carrying out in-depth clinical assessments and managing complex healthcare needs, including mental health conditions.
- The practice offered a GP telephone clinic which provided ten appointment slots every day. Daily telephone consultations were also available with advanced nurse practitioners. This benefitted patients who were unable to attend in person or who were unsure if their condition required a visit to the surgery.
- There were longer appointments available for patients with a learning disability. Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Reception staff had undertaken extra training to help them identify patients who needed extra support including patients displaying symptoms of memory loss or patients with particularly insecure accommodation arrangements and health care assistants had undertaken training to help them spot early symptoms of a wide range of conditions.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice had established a fitness and body conditioning club for patients. This was primarily intended to support patients with, or at risk of developing, long term health conditions and patients experiencing poor mental health. The practice also encouraged patients experiencing, or at risk of social isolation to participate. The practice provided weekly exercise classes under the supervision of a qualified fitness instructor and two of the practice health care assistants. The practice worked with a local gym to

Good

Are services responsive to people's needs?

(for example, to feedback?)

provide a suitable venue for classes and had agreed heavily discounted gym membership rates for members of the fitness and body conditioning club. The fitness instructor and healthcare assistants met with each patient individually to develop a personal exercise plan, details of which were added to the patients care plan at the practice. The club had an active membership of over 60 patients and average attendance at weekly classes was between 40 and 50 patients. We looked at records of eleven patients who attended the weekly classes and saw that blood sugar levels had reduced by 10% for four patients with diabetes, three patients had managed to reduce or stop certain medicines and three had achieved their targets for weight loss.

- GPs at the practice had special interests in dermatology, diabetes and substance misuse. The practice used a system of in-house patient referrals which meant that patients could receive specialist care at the surgery. The practice held a special dermatology clinic on Saturday mornings when the practice was otherwise quiet and patients from other practices could also be referred to this clinic. This clinic offered longer appointments without affecting access to routine GP appointments for the general practice population.
- The practice had recognised that some older patients and those with long term conditions experienced difficulty accessing community phlebotomy services and had trained one nurse practitioner and two healthcare assistants as phlebotomists to provide an in-house phlebotomy service. This service was available to all patients and was available by appointment from 8:00am every day. (Phlebotomists are clinicians trained to take blood samples from patients for testing in laboratories).
- There was a flexible approach to appointments for patients experiencing poor mental health and those living in circumstances which made them vulnerable. For instance, if a patient failed to attend an appointment, the practice would take steps to contact the patient but would not send a letter warning of the implications of failing to attend appointments. Patients with mental health needs could attend the surgery without an appointment and would be seen by either a doctor or an advanced nurse practitioner.
- The practice website included an extensive self-help section to support patients in managing their own day to day health. For instance, there was advice on what to keep in a domestic first aid kit and medicine box, there was information about maintaining good eyesight and dental hygiene, as well as a wide range of links to local and national health resources.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice website allowed patients to book or cancel appointments online and request repeat prescriptions. The website included a wide range of self-help information as well as information on how to stay healthy. Patients could also use the practice website to-self refer into the local physiotherapy service.
- The practice had developed its own in-house software to help GPs monitor the time taken during consultations. This consisted of a non-intrusive countdown timer on the computer screen. GPs told us this helped them to manage consultations more effectively.
- The practice had invested in a cloud based telephone system which included a voice based patient recognition system. This meant that a staff member answering an incoming call could greet the patient by name and see any messages or alerts relating to the patient.
- Information screens used to call patients to appointments had been installed on each wall in the waiting area to ensure that patients could see a screen regardless of where they were seated. As well as calling patients to appointments, screens were used to display health promotion information.
- There was an automated patient check-in system which could be accessed in seven locally prevalent community languages.

The practice had a policy which meant that homeless patients could register at the practice address. The practice had identified an increasing number of patients who, although not defined homeless, did not have permanent addresses and whose accommodation often consisted of short-term, informal arrangements with friends. The practice recognised that these arrangements were often chaotic and put patients' health and wellbeing at risk. A member of the reception team had been given a lead role in identifying patients in this category and would advise people living under these circumstances that they could

Good

Are services responsive to people's needs?

(for example, to feedback?)

register using temporary addresses and mobile telephone numbers. When the practice identified a person they considered needed this level of support, staff would bring this to the attention of a GP who would review the patient's record to investigate whether a referral to other support services should be considered. The practice told us that the insecure nature of these living arrangements meant that the number of patients affected fluctuated regularly but estimated that that up to ten patients were registered in this way at any one time.

Access to the service

The practice was open between 8:00am and 6:30pm on Monday, Thursday and Friday and between 8:00am and 8:00pm on Tuesday and Wednesday. Extended hours appointments were offered between 6:30pm and 8:00pm on Tuesday and Wednesday evenings. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. The practice was a member of a federated group of eleven local practices which provided pre-bookable appointments on Saturday mornings from 9:30am to 1:30pm.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 73% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 72% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

When a patient requested a home visit, reception staff would gather preliminary information which was reviewed by a GP. If further information was required, a GP could contact the patient to assess the urgency of the visit. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For instance, details of the complaints system were displayed on a notice board in the waiting area and on the practice website.
- The practice actively reviewed complaints to identify trends, underlying issues and to audit any improvements that had been made as a result of a complaint. As part of a recent review, the practice had involved the patient participation group in the process and had invited the Parliamentary and Health Service Ombudsman to visit the practice. During this visit, the practice had discussed its complaints process as well as the wider context of complaints within the primary medical services sector.

We looked at three complaints received in the last 12 months and found these hand been handled in line with the practices' procedure. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, we saw a complaint where a patient had been booked in for a certain minor procedure which required a patient to take certain steps prior to the appointment. On the day of the appointment, the clinician could not proceed as the patient had not been told about or undertaken the necessary preparations. The practice had reviewed the booking process for the procedure and had developed a template which staff now completed during the booking process, part of which involved discussing preparations with the patient. The patient had received a written apology.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

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

- The practice had a mission statement which had been shared with staff, who knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- GPs hosted patient education events at the practice to help patients become more involved in their own care. A recent talk on managing minor illnesses had featured talks by a GP, a community pharmacist and an experienced health care assistant and was attended by approximately thirty patients.
- Two GPs were undergraduate tutors at a medical school and one had also given talks at local schools about maintaining personal health and used these talks as opportunities to encourage young people to aspire to a career in medicine.
- The practice had taken innovative steps to improve access to care for patients. For instance, the practice had trained three health care assitants to provide additional support for patients with long term conditions and had recruited a physican associate to release GP time for more appointment slots. The practice had also created and recruited to a specialist administrative role whose responsibilities included reviewing all incoming correspondence, including hospital discharge letters and pathology results.
- The practice had created and supported a fitness and body conditioning club for patients which had more than 60 members. The practice could demonstrate how this had improved outcomes for patients.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice's GPs had written a wide ranging set of training manuals, operating procedures and rules of engagement for all clinical staff and these had been produced in a high quality print format. The practice undertook regular reviews to audit staff knowledge and compliance with practice procedures.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Outstanding ☆

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

- The practice provided opportunities and support to staff who wished to develop in their careers. For instance, the role of health care assistants had been expanded to safely undertake chronic disease management.
- Staff safety and well-being was prioritised by the practice. The practice could demonstrate how they had recently reviewed safety procedures and actions taken to maintain safety.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had a proactive approach to gathering feedback from patients. There was a suggestion box in the waiting area and the practice also used a text message based software system to survey patients who had recently registered or had made appointments and information about patient feedback was displayed in the waiting area and in staff offices.
- The PPG met regularly, carried out its own patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had been involved in arranging twice yearly health promotion and education events for patients. Events had already been held on managing minor illnesses and maintaining healthy skin and guest speakers had been arranged for an upcoming talk about diabetes. Patients attending these events were invited to provide feedback to assist in planning future events.
- The practice had gathered feedback from staff through staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. For instance, all staff were encouraged to look for and participate in training opportunities which contributed to a holistic approach to patient care. Reception staff had undertaken extra training to help them identify patients who needed extra support including patients displaying symptoms of memory loss or patients with particularly insecure accommodation arrangements and health care assistants had undertaken training to help them spot early symptoms of a wide range of conditions.

The practice team was forward thinking in its approach to improve outcomes for patients in the area. Having experienced difficulties recruiting additional GPs, the practice had instead recruited a Physician Associate to supplement the work of existing GPs and a specialist administrative role to relieve GPs of approximately 90% of correspondence duties. The practice had researched the range of training material available to support these roles and considered that further training and supervision models were needed to safely realise the full potential of these roles. Following this research, GPs had written and published their own training material and a implemented a supervision methodology which provided new staff with weekly sessions with GPs.

The practice's approach to understanding and managing the needs of patients with exceptionally high appointment bookings had been recognised as highly innovative by the local CCG and been shared widely and the practice had been invited to deliver presentations describing their approach.

The practice had sought feedback from patients to understand why information leaflets about conditions prevalent amongst the patient population were not being used. It had identified that patients found the language inaccessible and the appearance of the leaflets impersonal. As a result, the practice had developed its own range of information leaflets and had these printed professionally. Clinicians gave these to patients when they were helpful and a supply was held in the waiting area.

The practice had established a video streaming channel to provide practical advice to patients and had developed its own software to assist clinicians with time management during consultations.

The practice had been nominated for local and national awards and had recently received an award, 'Innovation Award for Improving Access' from the local CCG.