Nelson Medical Practice

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?	Requires improvement
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Nelson Medical Practice on 27 July 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events at practice and provider level.
- The practice had some defined and embedded systems to minimise most risks to patient safety. However, the system to ensure patients had received their medicines needed to be improved as we found prescriptions that had not been collected since February 2017.
- The daily check list for emergency medicines was incomplete; however all medicines were in date.
- Exception reporting for the Quality and Outcomes Framework (QOF) was high compared to local and national averages and uptake for breast and bowel screening was low. The practice were aware of this and had a policy and plan in place to address this.
- Results from the GP patient survey, published in July 2017, below average for several aspects of care. Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- The practice had identified 240 patients as carers (3.8% of the practice list).
- 30% of the practice population did not have English as a first language. The practice had recognised this and provided documents in different languages.
- The practice had a 'care connector' who went to local meetings with voluntary groups and helped to sign post patients to relevant local services.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

Summary of findings

- The infection prevention and control lead completed three monthly audits of room cleaning to ensure compliance.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management and East Coast Community Healthcare (ECCH). The practice proactively sought feedback from staff and patients, which it acted on. However, the practice had recently lost a clinical lead and were being supported by ECCH until a new lead was appointed.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We saw one area of outstanding practice:

- The practice held an information event in March 2017 to encourage fitness in patients registered at the practice. The practice had recognised that access to and involvement in exercise for their population group was limited. 60 patients attended the event and 58 signed up to the five week exercise plan. 38 patients had completed the 5 week plan and this enabled them to gain a free gym membership. This was an initiative of, and was funded by ECCH and had improved health outcomes for patients. ECCH hoped to run this event again.

The areas where the provider should make improvements are:

- Review the system for managing uncollected prescription scripts.
- Embed the policy and plan to reduce exception reporting ensuring that patients received appropriate follow ups.
- Review the system for the checking of emergency medicines.
- Continue to build on clinical leadership and active recruitment.
- Continue to monitor the effectiveness of actions taken in response to national GP Patient Survey, particularly in relation to patients' access to the service.

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.

- From the sample of documented examples we reviewed, we found there was an effective system 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 were informed as soon as practicable, received reasonable support, detailed information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had some defined and embedded systems, processes and practices to minimise risks to patient safety. However, the system to ensure patients had received their medicines needed to be improved as we found prescription scripts that had not been collected since February 2017.
- The infection prevention and control (IPC) audit was up to date and the lead for IPC had undertaken audits every three months to check the cleaning of the rooms and equipment.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents. All medicines checked were in date.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average. However, the practice was above average for exception reporting. The practice was aware of this and had a plan in place to address this.
- Performance for diabetes related indicators was 92%, this was comparable to the CCG and national average of 90%. The exception reporting rate was 29%, which was higher than the CCG average of 17% and the national average rate of 12%. The prevalence of diabetes was 7% which was equal to the CCG average and 1% above the national average.
- The practice were below national and local averages for breast and bowel screening.
- Staff were aware of current evidence based guidance.

Summary of findings

- Clinical audits demonstrated some quality improvement. For example, improvements had been made to diagnosing patients with COPD.
- Staff had the skills and knowledge to deliver effective care and treatment and were encouraged to attend courses to improve their clinical scope.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey, published in July 2017, showed patients rated the practice comparable to, or lower than others for several aspects of care.
- All of the 27 patient Care Quality Commission comment cards we received were positive about the service experienced.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- 30% of the practice population did not have English as a first language. The practice recognised this and provided documents in different languages. The electronic check in screen was also available in different languages.
- The practice had a care connector in place. The care connector went to local meetings with voluntary groups and helped to sign post relevant patients. This included referrals, for patients with social issues such as housing and debt, this assistance was provided with the patient's consent.
- The practice had identified 240 patients as carers (3.8% of the practice list).
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.

Summary of findings

- The practice held an information event in March 2017 to encourage fitness in patients registered at the practice. 38 patients had completed the 5 week plan and this enabled them to gain a free gym membership. This was an initiative of and funded by ECCH and had improved health outcomes for patients.
- Results from the GP patient survey, publish in July 2017, were below average for access to services. The practice had recognised this and implemented systems to improve this. Recent data from the practices' own patient satisfaction survey showed some improvement for access; however this data was from a relatively small number of patients.
- Patients we spoke with said that access to the surgery had improved with the new phone line system, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from seven examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and ECCH had a good oversight of the management of complaints.

Are services well-led?

Good

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

- The practice and East Coast Community Healthcare (ECCH) had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a leadership structure within ECCH and the practice and staff felt supported by management. The practice had policies and procedures to govern activity. However, there was a lack of clinical leadership within the practice due to staffing. ECCH were supporting the practice with monthly meetings from the medical director of ECCH, although these were not minuted, and planned to recruit a new clinical lead from September 2017.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify most risks. However, the practice had prescription scripts that had been uncollected dating back to February 2017; this had not been acknowledged or acted on

Summary of findings

- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. Staff reported the practice and ECCH were supportive of identified training needs. For example, a nurse had completed a prescribing course.
- The provider was aware of the requirements of the duty of candour. In three examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with a 'patients as teachers' event to gain feedback. They were also engaging with patients to set up another patient participation group as the established one had disbanded recently.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice offered weekly visits to local care homes. The practice also contacted the homes daily to establish if there were any concerns about patients and to help reduce unplanned admissions to hospital.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. They involved older patients in planning and making decisions about their care, including their end of life care. The practice also held meetings with the MacMillan nurses to discuss these patients.
- The practice followed up on older patients discharged from hospital and ensured their care plans were updated to reflect any extra needs and offered appointments where required.
- Where older patients had complex needs, the practice shared summary care records with local care services. The practice also held regular meetings with a range of healthcare professionals, including district nurses.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management, including respiratory complications and diabetes. Patients at risk of hospital admission were identified as a priority.
- The practice had an avoiding unplanned admissions register which was monitored and gave patients a range of options for access to the appropriate health care professional.
- Performance for diabetes related indicators was 92%, this was comparable to the CCG and national average of 90%. The

Summary of findings

exception reporting rate was 29%, which was higher than the CCG average of 17% and the national average rate of 12%. The prevalence of diabetes was 7% which was equal to the CCG average and 1% above the national average.

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named clinician and there was a system to recall patients for 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. This included the district nurses and social services.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed 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.
- Immunisation rates were in line with national targets for all standard childhood immunisations. Children requiring immunisations had open access appointments, which meant they could be seen without pre-booking an appointment. The practice also phoned all patients who did not attend for childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. There were toys in the waiting room available for use.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal and post-natal care.
- The practice had emergency processes for acutely ill children and young people.
- The practice also offered open access appointments to support urgent family planning issues.

Summary of findings

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 practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours.
- The practice was proactive in offering online services and text message reminders.
- The practice offered a full range of health promotion and screening that reflects the needs for this age group, including smoking cessation and alcohol advice.
- The practice held an information event in March 2017 to encourage fitness in patients registered at the practice. This enabled them to gain a free gym membership which improved health outcomes for the participants. This was an ECCH initiative and funded by ECCH.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had an open access system for vulnerable patients.
- 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 offered longer appointments for patients with a learning disability and those requiring translation services.
- The practice had 46 patients on the learning disability register and had reviewed 38 of these patients.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients, including social services and district nurses.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations, including domestic abuse.
- The practice had a member of staff trained in domestic abuse who could advise on local support groups and recognise the signs of domestic abuse. There was also a member of staff trained in sign language.
- The practice had a care connector, who liaised with local groups and charities and signposted patients where appropriate.

Summary of findings

- Staff we spoke with knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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. There were signs in all clinical rooms detailing contact numbers.

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).

- The practice carried out advance care planning for patients living with dementia.
- 69% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was lower than the clinical commissioning group average of 74% and the national average of 78%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. For example, the practice had open access for vulnerable patients, including those with poor mental health.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs, but this needed improving. We found repeat prescriptions that had not been collected from February 2017. The practice had not reviewed these.
- The practice had 55 people on the mental health register, 38 of these had their care plans reviewed in the last year.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia. This involved close working with a local mental health team.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed 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 2017. The results showed the practice was performing below local and national averages. 382 survey forms were distributed and 119 were returned. This represented a 31% response rate.

- 73% of patients described the overall experience of this GP practice as good compared with the CCG average of 87% and the national average of 85%.
- 55% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 61% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 82% and the national average of 77%.

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. Comments received related to improved access to the surgery, the caring nature of the staff and the kindness of reception staff.

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.

Areas for improvement

Action the service SHOULD take to improve

- Review the system for managing uncollected prescription scripts.
- Embed the policy and plan to reduce exception reporting ensuring that patients received appropriate follow ups.
- Review the system for the checking of emergency medicines.
- Continue to build on clinical leadership and active recruitment.

Outstanding practice

- The practice held an information event in March 2017 to encourage fitness in patients registered at the practice. The practice had recognised that access to and involvement in exercise for their population group was limited. 60 patients attended the event and 58 signed up to the five week exercise plan. 38 patients had completed the 5 week plan and this enabled them to gain a free gym membership. This was an initiative of, and was funded by ECCH and had improved health outcomes for patients. ECCH hoped to run this event again.

Nelson Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Nelson Medical Practice

In 2011, Nelson Medical Practice joined East Coast Community Healthcare Community Interest Company (ECCH), who are the provider for the practice. ECCH is a provider of over 30 community services, which includes four GP practices and has been established for six years.

Nelson Medical Practice provides services to approximately 6,400 patients in an urban area in Great Yarmouth. The practice has one male salaried GP. There is a practice manager on site. The practice employs two practice nurses and two advanced nurse practitioners. The practice also employs one health care assistant. East Coast Community Healthcare also provides a primary care practitioner and a pharmacist. Other staff include seven receptionists, one secretary, one reception manager, one prescribing administrator and a deputy practice manager. The practice holds an Alternative Provider of Medical Services contract with NHS England. Nelson Medical Practice is a training practice for student nurses and two of the nurses are trained for this role.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are available between 7.30am and 8am on Mondays and Fridays. Appointments can be booked up to four weeks in advance with the GP and nurses. Urgent appointments are available for people that need them, as well as telephone appointments. Online appointments are available to book up to one month in advance.

When the practice is closed patients are automatically diverted to the GP out of hour's service provided by Integrated Care 24. Patients can also access advice via the NHS 111 service.

We reviewed the most recent data available to us from Public Health England which showed the practice has a smaller number of patients aged 70 to 89 years old compared with the national average. It has a larger number of patients aged 20 to 39 compared to the national average.

Income deprivation affecting children is 39%, which is higher than the CCG average of 26% and national average of 20%. Income deprivation affecting older people is 29%, which is higher than the CCG average of 17% and national average of 16%. Life expectancy for patients at the practice is 75 years for males and 81 years for females; this is comparable to the CCG and England expectancy which is 80 years and 83 years.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, including the clinical commissioning group to share what they knew. We carried out an announced visit on 27 July 2017. During our visit we:

- Spoke with a range of staff, including a GP, nurses, a pharmacist, reception and admin staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with patients
- Reviewed a 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.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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 living 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 a system 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 practice also reported significant events through a Datix reporting system which alerted East Coast Community Healthcare (ECCH). ECCH monitored the practice response and discussed significant events to monitor trends. The practice also discussed significant events in clinical meetings and kept a log of significant events, actions taken and lessons learned.
- 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).
- From the sample of three documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, detailed information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice had a process for managing patient safety alerts. They were managed by the pharmacist and records viewed showed searches for historic safety alerts which may remain relevant were completed.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice implemented a process to monitor letters sent to patients that required urgent review. They had set up a waiting list, which was regularly reviewed, and if the patient did not make contact with the practice after three attempts, the GP was notified.

Overview of safety systems and processes

The practice had systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff and there was guidance of who to contact in clinical rooms. 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 and staff spoken to were aware of who this was. Staff provided reports where necessary for other agencies.
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. The GP and nursing staff were trained to child protection or child safeguarding level three.
- 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). The chaperone and the clinician recorded their presence in patient notes.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. The cleaning schedules for individual rooms and equipment were audited every three months to ensure compliance.
- The advanced nurse practitioner was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The IPC lead also assisted the induction of new staff covering areas such as hand hygiene, personal protective equipment and sharps injuries.

Good

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised most risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. The provider was able to demonstrate that they were aware of all patients on high risk medicines; regular audits and searches ensured patients had appropriate monitoring. Repeat prescriptions were signed before being given to patients and there was a process to ensure this occurred. However, on the day of inspection, we found scripts that had not been collected or destroyed since February 2017, the practice had not acknowledged this. The practice reported they would review this system.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group 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 to monitor their use.
- Two of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and clinical supervision from the medical staff for this extended role. Patient group directions 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 and patient specific prescriptions or directions from a prescriber were produced appropriately. There was an effective system in place to ensure these were signed and up to date.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. The practice had not formalised the role of the emergency care practitioner as the role did not have a job description. After the inspection, the practice sent evidence of a job description which had been signed and dated by the practice manager and employee.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and a completed risk assessment which had a comprehensive action plan in place.
- The practice had an up to date fire risk assessment and completed action plan. The practice had carried out regular fire drills. There were three designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. However, the practice had lost a clinical lead so there was limited GP input into the rotas. The practice had recognised this and used other appropriate health professionals such as nurses, a pharmacist and an emergency care practitioner.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements 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.
- 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.

Good

Are services safe?

- 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 checked the emergency equipment and medicines daily. However, the daily check list did not include a full list of which medicines were checked. There were in date defibrillator pads on the emergency trolley, however there were also out of date pads on the emergency trolley for training purposes. These were removed on the day of inspection.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems 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. This guidance was available on the practice computer system.
- The practice monitored that these guidelines were followed through regular clinical meetings, held every six weeks.

Management, monitoring and improving outcomes for people

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 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 96%.

The overall exception reporting was 27% which was 13% above the CCG average and 17% above the national average. (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). The practice recognised this was high compared to the averages. Unverified data from 2016/17 showed exception reporting had reduced to 21%. The practice had implemented a policy to reduce exception reporting which outlined a new protocol for who could be exception reported and a new did not attend protocol. This involved phoning patients three times and passing information on to the GP. The practice hoped this will further reduce exception reporting.

Data from 2015/16 showed:

- Performance for diabetes related indicators was 92%, this was comparable to the CCG and national average of 90%. The exception reporting rate was 29%, which was higher than the CCG average of 17% and the national average rate of 12%. The prevalence of diabetes was 7% which was equal to the CCG average and 1% above the national average.
- Performance for mental health related indicators was 100%. This was 10% above the CCG average and 7% above the national average. The exception reporting rate was 39%, which was higher than the CCG average of 19% and national average of 11%. The prevalence of patients with recorded mental health conditions in the practice was 1%, which was equal to the CCG and national averages.
- Performance for dementia related indicators was 100%, which was 5% above the CCG average and 3% above the national average. The exception reporting rate was 28%, which was above the CCG average of 14% and national average of 13%. The prevalence of dementia was 1% which was equal to the CCG and national averages.
- The prevalence of patients recorded as having depression was 11%, which was higher than the CCG prevalence of 10% and national prevalence of 8%. The performance for depression related indicators was 100%. This was 5% above the CCG average and 3% above the national average. The exception reporting rate was 35%, which was higher than the CCG average of 26% and national average of 22%.

There was evidence of quality improvement including clinical audit:

- There had been three clinical audits commenced in the last year, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, due to an audit on COPD, a new process was in place for diagnosing patients. Following their appointment with the nurse all patients with suspected COPD were booked in with a GP to confirm diagnosis and the treatment plan.
- The practice was active in many research projects, including studies on kidney medicines, heart medicines, lung and bowel cancer identification and prevention of bleeding ulcers in people taking aspirin.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- 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. New staff also had a role specific induction with the practice.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, those reviewing patients with long-term conditions had completed relevant training such as diabetes diplomas. A nurse had also completed the prescribing course to become an independent prescriber.
- 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, clinical supervision and facilitation and support for revalidating nurses. All staff had received an appraisal within the last 12 months. Due to the vacancy of a clinical lead GP within the practice, the salaried GP received clinical support from the clinical lead within ECCH on a monthly basis as the new clinical GP lead was due to start with the practice in September 2017.
- 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.

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.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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 work with MacMillian nurses, district nurses, social services and the health visitor. The practice also liaised with other services when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals every six weeks when care plans were routinely reviewed and updated for patients with complex needs.

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.

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.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

Good

Are services effective?

(for example, treatment is effective)

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, exercise and those with social issues.
- The practice provided rooms for other agencies including the midwife, continence services, aortic screening, a smoking cessation advisor and a chronic fatigue syndrome clinic.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 83% and the England average of 82%. Patients who did not attend for their cervical screening test were followed up to encourage attendance. There were systems 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.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice phoned all patients who did not attend and answered questions about the procedure and offered appointments at a time that suited the patient.

- 40% of patients aged 60 to 69 had been screened for bowel cancer in the last 30 months which was significantly lower than the CCG average of 60% and the England average of 58%.
- 59% of females aged 50 to 70 had been screened for breast cancer in the last 36 months which was significantly lower than the CCG average of 72% and an England average of 73%.

Childhood immunisation rates were in line with CCG and England averages. Flexible appointments were available for patients receiving childhood immunisations and the practice also had an open access system. This ensured that children could be seen without a formal appointment for immunisations.

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. The practice had 46 patients on the learning disability register and had completed 38 reviews of these patients.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed several caring interactions between staff members and patients. We observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- On the day of inspection, we observed that reception staff could identify when patients wanted to discuss sensitive issues or appeared distressed, and they could offer them a private room to discuss their needs.
- Patients could be treated by male or female clinicians.

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 five patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey, published in July 2017, showed patients felt they were treated with compassion, dignity and respect by nursing staff; however patient satisfaction with GP consultations was below average. For example:

- 79% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 72% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 86%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 77% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 86%.
- 97% of patients said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 91%.
- 92% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 98% of patients 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 said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

The practice was aware of the lower figures for the GP patient survey and had taken steps to improve this. This included surveys run by the practice and a 'patients as teachers event' to gain further feedback from patients on how to improve the service provided.

Care planning and involvement in decisions about care and treatment

Patients we spoke to on the day of inspection 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 saw that care plans were personalised. Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey, published in July 2017, showed patients responded in a mixed way to

questions about their involvement in planning and making decisions about their care and treatment. Results were mixed compared with local and national averages. For example:

- 79% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 86%.
- 65% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 92% of patients 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%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

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

- 30% of the practice population did not have English as a first language. The practice recognised this and provided forms in different languages. The electronic check in screen was also available in different languages.
- Staff told us that interpretation 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. Reception routinely booked double appointments for these patients. A member of staff had also completed a sign language course.
- Information leaflets were available in easy read format. Information was also available in different languages.

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. These included information on cancer, dementia, carers and domestic abuse. There was member of staff who led on domestic abuse within the practice. Information about local support groups was available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice had a 'care connector' in place, this role was developing to further enhance the support given to patients and carers. The care connector went to local meetings with voluntary groups and helped to sign post relevant patients. This included referrals for patients with social issues such as housing and debt, this assistance was provided with the patient's consent.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 240 patients as carers (3.8% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Staff checked if a patient was still a carer during consultations and ensured records were kept up to date.

Staff told us that if families had experienced bereavement, their usual GP contacted them and sent an information pack. This included information on bereavement services, how to register a death, who to inform of a death and how to tell children. Appointments were available for bereaved patients if required.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Monday and Friday mornings from 7.30am to 8am for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and those requiring translation services.
- The practice population had 30% of patients for whom English was not their first language. The practice had recognised this and had forms available in different languages.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The practice completed weekly ward rounds at the local care homes and had daily contact with them to avoid unplanned admissions to hospital.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning. The practice also held meetings with the MacMillan nurse.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. The practice also operated an 'open access' clinic for children requiring immunisations and urgent family planning advice and treatment. This ensured these patients were seen as quickly as possible for treatment.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS.
- The practice held an information event in March 2017 to encourage fitness in patients registered at the practice. The practice had recognised that access and involvement in exercise for their population group was limited. 60 patients attended the event and 58 signed up to the 5 week exercise plan. 38 patients had completed the 5 week plan and this enabled them to gain a free gym membership. This was an initiative of and funded by East Coast Community Healthcare (ECCH) and had improved health outcomes for patients.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 5pm daily. A duty clinician was on call between 8am to 8.30am and 5pm to 6pm daily. Extended hours appointments were offered between 7.30am and 8am on Mondays and Fridays. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey, published in July 2017, showed that patient's satisfaction with how they could access care and treatment was below the local and national averages.

- 75% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 47% of patients said they could get through easily to the practice by phone compared to the CCG average of 77% and the national average of 71%.
- 71% of patients 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 88% and the national average of 84%.
- 68% of patients said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 55% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 50% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 58% and the national average of 58%.

The practice acknowledged that these results were low compared to the averages. The practice had put a new phone line in place in April 2017. Results from the practice own satisfaction survey, which had 23 respondents, stated that 52% reported it was easy to get through to the practice by phone in March 2017, compared to an increase to 76% after the installation of the phone line in June 2017. The

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

June 2017survey had 38 respondents. The practice had also improved appointment access by including an 'open access' system for vulnerable patients, children and patients requiring urgent family planning advice and treatment. The practice planned to run another 'patients as teachers' event to see how they can further improve patient satisfaction with access to the surgery.

The practice had also implemented strategies to signpost patients to the most appropriate service and clinician on their first contact. Alongside this, the practice was also taking part in the productive general practice programme. As a part of this, the practice had focussed on making processes including scanning and management of hospital correspondence more efficient. This freed up time for the reception and administration staff to focus on patients. The practice had also utilised telephone appointments where appropriate to increase the number of face to face appointments available, and also to treat patients in the most appropriate way, which had improved waiting times.

Patients told us on the day of the inspection that they were able to get appointments when they needed them, and that this had improved since the installation of the new phone lines. The practice had a system to assess:

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

An administrative team member gathered information relating to the visit request from the caller and added this to the list for the duty clinician to decide whether a visit was clinically appropriate. 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 a system for handling complaints and concerns.

- The 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. There were complaints forms available in reception. Reception also held a feedback book to record dissatisfaction from patients in reception. There was also a verbal complaints form available.

The practice had received six verbal and seven written complaints in the last 12 months. We looked at all seven written complaints and found these were handled satisfactorily, in a timely way and with openness and transparency. Lessons were learned from individual concerns and complaints. For example, the phone lines had recently been changed. ECCH carried out a quarterly trend analysis of complaints and the practice carried out an annual trend analysis of complaints. Verbal complaints were discussed at staff meetings to identify any trends.

Are services well-led?

Good

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

Our findings

Vision and strategy

East Coast Community Healthcare (ECCH) had been an established community interest social enterprise for six years. They formed a partnership with Nelson Medical Practice in 2011 and assumed responsibility for the practice. Staff reported that ECCH were well embedded in the practice.

ECCH's vision was 'We will be a ground-breaking, forward thinking community focused social enterprise with a reputation for excellence and quality in improving health and wellbeing.' This was promoted by the practice and staff we spoke to were aware of the vision and strategy and their responsibilities in relation to it. The vision was displayed in the practice. ECCH had a strategy and supporting business plan for the practice which supported the vision and strategy and this was regularly monitored.

Governance arrangements

There was an organisational structure for Nelson Medical Practice, which detailed the reporting relationships from frontline staff to the ECCH executive team. ECCH had a governance framework for primary care which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas such as infection control, safeguarding and domestic abuse.
- ECCH had implemented practice specific policies which were available to all staff. These were updated and reviewed regularly and any updates were emailed to staff.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. ECCH also met with the management team regularly to feedback on performance and develop action plans. For example, the practice had high levels of exception reporting. As a result, ECCH and the practice developed and implemented a policy for exception reporting with the overall aim to reduce exception reporting.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- The practice was active in many research projects, including studies on kidney medicines, heart medicines, lung and bowel cancer identification and prevention of bleeding ulcers in people taking aspirin.
- There were appropriate arrangements for identifying, recording and managing most risks, issues and implementing mitigating actions. For example, the infection prevention and control lead completed audits every three months on the cleaning of clinical rooms and equipment. However, the practice had prescription scripts that were uncollected dating back to February 2017. The practice had in date emergency medicines, however, did not have a complete list of which medicines had been checked.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. These were also discussed within ECCH and feedback was given to the practice.
- The practice were seeking alternative ways to gain patient feedback in order to improve patient satisfaction outcomes.

The governance structure of ECCH was made up of eight committees including the policy group, strategic HR Education and training group, safeguarding committee, medicines management committee, health and safety committee, infection prevention and control committee, medical devices management group and primary care, which fed directly into the Integrated Governance Committee (IGC). The IGC was chaired by a non-executive director (NED) and was responsible for patient safety, risk management, patient involvement, complaints and human resources and workforce. The IGC met every two months and reported directly to the ECCH board. The remuneration committee, audit committee and shareholder council also reported directly to the ECCH board. Information regarding Nelson Medical Practice and collated information for ECCH GP practices was reported as appropriate to the IGC.

Leadership and culture

On the day of inspection the management team in the practice and ECCH demonstrated they had the experience,

Are services well-led?

Good

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

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 ECCH were approachable and always took the time to listen to all members of staff. The practice had recently lost a clinical lead. ECCH had risk assessed this and as a result, implemented monthly meetings with the salaried GP in the practice and the clinical lead from ECCH to discuss any clinical matters. ECCH were actively recruiting for another GP to assist in leading the management team within the practice and they were due to start in September.

The provider was aware of and had systems 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). ECCH and the management team within the practice encouraged a culture of openness and honesty. Staff spoken with reported they would feel supported to feedback within the practice and to ECCH if required. From the sample of three documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, detailed information and a written apology.
- The practice kept written records of verbal interactions as well as written correspondence and had a feedback book in reception for staff to record comments.

There was a leadership structure within the practice and staff felt supported by management.

- The practice held and recorded a range of multi-disciplinary meetings including meetings with district nurses, McMillan nurses and social workers to monitor vulnerable patients and any safeguarding concerns.
- Staff told us the practice held regular team meetings every month. Staff told us there was an open culture within both the practice and ECCH and they would feel confident to raise any issues in these meetings. The practice manager met with ECCH on a regular basis to discuss the practice. Staff we spoke with reported ECCH were visible within the practice and easy to communicate with.
- Staff said they felt respected, valued and supported, by the practice and by ECCH. All staff were involved in discussions about how to run and develop the practice, and the practice encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example, following feedback from a nurse practitioner at a meeting the practice had implemented an open access system for urgent family planning advice and treatment and childhood immunisations.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through surveys, the NHS Friends and Family test, a 'patients as teachers' event and complaints and compliments received. The members of the patient participation group (PPG) had recently disbanded and the practice was keen to set up another by actively recruiting new members. The practice manager was engaging with patients and exploring the idea of a virtual PPG. The practice had completed a 'patients as teachers' event which was a focus group of patients that explored issues and ideas within the practice. From this event, and the patient satisfaction survey, the practice actioned the installation of a new phone system. The practice planned to hold another 'patients as teachers' event and survey results for accessing the practice had improved.
- Staff through meetings, appraisals and induction. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and were encouraged to feedback ideas to improve the service. Staff told us they felt involved and engaged to improve how the practice was run. For example, a member of staff had suggested open access clinics for children and urgent family planning advice and treatment, and this had proved popular with the patients. ECCH rewarded staff with staff awards and recognition for long service to the NHS.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and involved staff in this. The practice and ECCH had supported a nurse to complete their

Are services well-led?

Good

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

master's degree and prescribing qualification. ECCH had planned initiatives to place a physiotherapist and health coach at the practice to give healthy living advice to patients. The practice was embedding social prescribing, signposting and referring patients to the relevant groups for help with social issues.