Boughton Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Boughton Medical Group on 18th October 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. Staff were aware of procedures for safeguarding patients from the risk of abuse.
- There were systems in place to reduce risks to patient safety, for example, premises and equipment checks, medication management and the management of staffing levels.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff felt well supported. They had access to training and development opportunities and had received training appropriate to their roles.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw staff treated patients with kindness and respect.
- Services were planned and delivered to take into account the needs of different patient groups.
  - Access to the service was monitored to ensure it met the needs of patients.
- Information about how to complain was available. There was a system in place to manage complaints.
- There were systems in place to monitor and improve quality and identify risk.

We saw areas of outstanding practice:

- The practice had been identified as a beacon practice for on-line patient access by NHS England and had made a video for use throughout English GP

practices to encourage patients to register for this service. The practice had worked together with their Patient Participation Group (PPG) to develop this service and promotional material for on-line access. The practice had approximately 26% of their patient population registered for on-line access. The practice and the PPG had also linked up with local services to provide computer training and set up email accounts to enable patients to use on-line access.

- The practice had developed and recently implemented its own autism protocol. This acted as an aide memoire to staff when booking appointments for patients with suspected or diagnosed autism and suggested reasonable adjustments to be made when attending the practice. It also stressed the importance of good communication with patients and their families or carers.
- The practice website and newsletter had sections specifically for young people which included information on common health questions, abuse prevention, sexual health and smoking and links to health and social care support organisations.
- The practice had been involved in a number of community engagement projects in the last two years. For example, members of the clinical and management team collaborated with a local supermarket to deliver lifestyle advice and carry out patient health checks in a specially adapted vehicle owned by the supermarket and located in its car park. The practice team visited a local pre-school to explain to children about what to expect when visiting their GP. The practice also promoted student health by providing information about the practice and the services offered at the Fresher's Fayre.
- Two nurses from the practice had undertaken a study between 2012 and 2014 with the aim of assessing the effectiveness of early diagnosis of dementia and how this impacts on individuals and carers. The conclusions and recommendations included reducing waiting times for diagnosis and that the benefits of earlier diagnosis should continue to be promoted. As a consequence of the findings the practice had been involved in and developed services. Opportunistic screening for dementia took place. Following on from this the practice also offered an in-house dementia care assessment led by a nurse. This involved a 30 minute assessment of the patient and symptoms, followed by a memory assessment. If further investigations were needed the patient was referred on to specialist services. The practice had been part of the nurse led Vulnerable Housebound Adult Service pilot. The aim of this pilot was to improve the experience and outcomes for housebound, vulnerable, frail and elderly patients by advanced care planning and management. Dementia screening and review was included within this service provision. This included a full holistic assessment, an assessment of the patient's carer to ensure they were receiving sufficient support and sign posting for support service services and referrals to health and social care services as necessary.

The areas where the provider should make improvements are:

- Ensure there is a daily record of the minimum and maximum thermometer readings for vaccine fridges.

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. Safety events were reported, investigated and action taken to reduce the chance of a re-occurrence. There were appropriate systems in place to ensure that equipment was safe to use and the premises were safe. We found that the minimum and maximum thermometer readings for the vaccine fridges were not recorded. We were informed following our visit that action had been taken to address this. We also found that one item of equipment was not retained in original packaging detailing instructions and use by date. Confirmation that this had been addressed was provided to us following the inspection. There were systems to protect patients from the risks associated with insufficient staffing levels, medicines management and infection control. Staff were aware of procedures for safeguarding patients from risk of abuse. The recruitment records showed all appropriate information had been obtained for staff employed by the practice. The records of self-employed GP locums did not contain all the required recruitment information. This was addressed during the course of the inspection.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Staff worked with other health care teams and there were systems in place to ensure appropriate information was shared. Staff had access to training and development opportunities and had received training appropriate to their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. We saw that staff treated patients with kindness and respect. Patients spoken with and who returned comment cards were positive about the care they received from the practice. They commented that they were treated with respect and dignity and that staff were caring, supportive and helpful. Patients felt involved in planning and making decisions about their care and treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Services were planned and delivered to take into account the needs

Summary of findings

of different patient groups. Access to the service was monitored to ensure it met the needs of patients.The practice had a complaints policy which provided staff with clear guidance about how to handle a complaint.	
Are services well-led? The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance and staff meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and worked effectively with the practice team. There was a strong focus on continuous learning and improvement at all levels.	Good 

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 was knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions and used this information to plan reviews of health care and to offer services such as vaccinations for flu and shingles. Each patient has a named GP to ensure continuity of care. The practice provided services to a local nursing home. Visits were carried out by the advanced nurse practitioner twice a week to respond to acute symptoms, minor illness and injury. The advanced nurse practitioner was also available for daily telephone consultations with the nursing home staff and this included issues/ concerns that required urgent action prior to the twice weekly visit. The practice nurse visited the nursing home to monitor long term conditions and GPs visited if a patients' condition deteriorated and to carry out six monthly reviews of patient care. This service had led to better co-ordination of patient care and had assisted with avoiding unplanned admissions to hospital. The practice worked with other agencies and health providers to provide support and access specialist help when needed. Multi-disciplinary meetings were held to discuss and plan for the care of frail and elderly patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice held information about the prevalence of specific long term conditions within its patient population such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. This information was reflected in the services provided, for example, reviews of conditions and treatment, screening programmes and vaccination programmes. The practice had a system in place to make sure no patient missed their regular reviews for long term conditions. Patients with long term conditions had management plans in place which empowered them to manage their conditions. The practice aimed to ensure that patients were able to see one nurse for all of their long term conditions to reduce the need for multiple appointments. The practice offered patient access to their care records and they were promoting this to patients with a long term condition. This encouraged patients to manage their conditions and improved patients' health by providing self-care tools. The practice offered annual reviews to patients who have had a splenectomy and to patients who had been diagnosed with coeliac disease. These

reviews were in addition to the contractual requirements of the practice as the importance of these reviews had been identified for promoting patients' wellbeing. These patients were offered a review with the nursing team and immunisations in accordance with current guidelines. The clinical staff took the lead for different long term conditions and kept up to date in their specialist areas. The practice had multi-disciplinary meetings to discuss the needs of palliative care patients and patients with complex needs. The practice worked with other agencies and health providers to provide support and access to specialist help when needed. The practice referred patients with a long term condition to Self-Management UK who provided a free six week course for patients to help them manage the day to day impact of living with a long term condition.The practice referred patients who were over 18 and with long term health conditions to a well-being co-ordinator for support with social issues that were having a detrimental impact upon their lives.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Child health surveillance and immunisation clinics were provided. Appointments for young children were prioritised. Minor illness clinics with the nurse practitioner were also provided. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had access to a system that allowed direct access to paediatricians at The Countess of Chester Hospital which enabled speedier diagnosis and treatment as well as reducing further primary care appointments and unnecessary referrals to hospital. The staff we spoke with had appropriate knowledge about child protection and all staff had safeguarding training relevant to their role. The safeguarding lead staff liaised with school health, midwives and health visiting colleagues to discuss any concerns about children and how they could be best supported. The health visiting and school nursing service were based in the same building as the practice which assisted with good communication. Contraception and sexual health services were provided. There was a section on the practice website and in the practice newsletter specifically for young people. The Patient Participation Group (PPG) were working with a local college to encourage students to be part of the PPG which would enable the views of younger patients to be considered.

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 offered pre-bookable appointments, book on the day appointments and

telephone consultations. Patients could order repeat prescriptions and book appointments on-line which provided flexibility to working patients and those in full time education. The practice was open from 8am to 6.30pm Monday to Friday allowing early morning and evening appointments to be offered to working patients. An extended hour's service for routine appointments and an out of hour's service were commissioned by West Cheshire CCG and provided by Cheshire and Wirral Partnership NHS Foundation Trust. The practice website provided information around self-care and local services available for patients. The practice offered health promotion and screening that reflected the needs of this population group such as cervical screening, NHS health checks, smoking cessation advice and family planning services. The practice used eConsult a platform that enabled patients to self-manage and consult online with their own GP through their practice website. The benefits of this system included improved access and improved health outcomes through earlier detection of significant symptoms and earlier intervention. An express clinic was run twice a day by a nurse practitioner who was able to assist with many illnesses such as sore throats, chest and ear infections, prescribe medication and allocate a GP appointment if necessary. Reception staff sign-posted patients who do not necessarily need to see a GP. For example to services such as Pharmacy First (local pharmacies providing advice and possibly reducing the need to see a GP) and the Physio First service (this provided physiotherapy appointments for patients without the need to see a GP for a referral).

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. Patients' electronic records contained alerts for staff regarding patients requiring additional assistance. For example, if a patient had a learning disability to enable appropriate support to be provided. There was a recall system to ensure patients with a learning disability received an annual health check. The practice had developed and recently implemented its own autism protocol. This acted as an aide memoire to staff when booking appointments for patients with suspected or diagnosed autism and suggested reasonable adjustments to be made when attending the practice. It also stressed the importance of good communication with patients and their families or carers. The practice prioritised patients who may be at risk of poor health due to frailty. Following a medical event such as unplanned hospital attendance the medical needs of these patients were reviewed to identify what could be put in place to prevent future ill-health or hospital admission. The staff we spoke with had appropriate knowledge about safeguarding vulnerable adults and all staff had safeguarding training relevant to their role.

Summary of findings

Services for carers were publicised and a record was kept of carers to ensure they had access to appropriate services. Two members of staff acted as carer's links and they were working to identify carers and promote the support available to them through organisations such as the Carers Trust. The practice referred patients to local health and social care services for support, such as drug and alcohol services and to the wellbeing coordinator.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated outstanding for the care of people experiencing poor mental health (including people with dementia). Two nurses from the practice had undertaken a study between 2012 and 2014 with the aim of assessing the effectiveness of early diagnosis of dementia and how this impacts on individuals and carers. The conclusions and recommendations included reducing waiting times for diagnosis and that the benefits of earlier diagnosis should continue to be promoted. As a consequence of the findings the practice had been involved in and developed services. Opportunistic screening for dementia took place. Following on from this the practice also offered an in-house dementia care assessment led by a nurse. This involved a 30 minute assessment of the patient and symptoms, followed by a memory assessment. If further investigations were needed the patient was referred on to specialist services. The practice had been part of the nurse led Vulnerable Housebound Adult Service pilot. The aim of this pilot was to improve the experience and outcomes for housebound, vulnerable, frail and elderly patients by advanced care planning and management. Dementia screening and review was included within this service provision. This included a full holistic assessment, an assessment of the patient's carer to ensure they were receiving sufficient support and sign posting for support service services and referrals to health and social care services as necessary.

GPs worked with specialist services to review care and to ensure patients received the support they needed. The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients experiencing poor mental health, including dementia, an annual health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services. The practice had information in the waiting areas about services available for patients with poor mental health. For example, services for patients who may experience depression. Clinical and non-clinical staff had undertaken training in dementia to ensure all were able to appropriately support patients.

Summary of findings

What people who use the service say

Data from the National GP Patient Survey July 2016 (data collected from July-September 2015 and January-March 2016) showed that the practice was performing above or in-line with local and national averages. The practice distributed 247 forms, 110 (45%) were returned which represents approximately 1% of the total practice population. The results showed:-

- 81% of patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 73%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and national average of 85%.
- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 78% patients described their experience of making an appointment as good compared to the CCG average of 75% and national average of 73%.
- 67% of patients with a preferred GP said they usually get to see or speak to that GP compared to the CCG average of 58% and national average of 59%.
- 93% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and national average of 85%.
- 84% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and national average of 78%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 13 comment cards which were all positive about the standard of care received. We spoke with eight patients during the inspection. They said that clinical staff listened to their concerns and treated them with compassion and empathy. Feedback from patients indicated they were able to get an appointment when one was needed, they could get through to the practice easily by telephone and that they were happy with opening hours.

The practice sought patient feedback by utilising the Friends and Family test (FFT). This test is an opportunity for patients to provide feedback on their care and treatment. It was available in GP practices from 1 December 2014. Results from July to September 2016 showed that 265 responses had been received and out of these 247 (93%) patients were either extremely likely or likely to recommend the practice to family or friends.

Areas for improvement

Action the service SHOULD take to improve

- Ensure there is a daily record of the minimum and maximum thermometer readings for vaccine fridges.

Outstanding practice

- The practice had been identified as a beacon practice for on-line patient access by NHS England and had made a video for use throughout English GP practices to encourage patients to register for this service. The practice had worked together with their Patient Participation Group (PPG) to develop this service and promotional material for on-line access. The practice had approximately 26% of their patient population registered for on-line access. The practice and the PPG had also linked up with local services to provide computer training and set up email accounts to enable patients to use on-line access.

Summary of findings

- The practice had developed and recently implemented its own autism protocol. This acted as an aide memoire to staff when booking appointments for patients with suspected or diagnosed autism and suggested reasonable adjustments to be made when attending the practice. It also stressed the importance of good communication with patients and their families or carers.
- The practice website and newsletter had sections specifically for young people which included information on common health questions, abuse prevention, sexual health and smoking and links to health and social care support organisations.
- Two nurses from the practice had undertaken a study between 2012 and 2014 with the aim of assessing the effectiveness of early diagnosis of dementia and how this impacts on individuals and carers. The conclusions and recommendations included reducing waiting times for diagnosis and that the benefits of earlier diagnosis should continue to be promoted. As a consequence of the findings the practice had been involved in and developed services. Opportunistic screening for dementia took place. Following on from this the practice also offered an in-house dementia care assessment led by a nurse. This involved a 30 minute assessment of the patient and symptoms, followed by a memory assessment. If further investigations were needed the patient was referred on to specialist services. The practice had been part of the nurse led Vulnerable Housebound Adult Service pilot were housebound patients were provided with an annual review of their dementia. This included a full holistic assessment, an assessment of the patient's carer to ensure they were receiving sufficient support and sign posting for support service services and referrals to health and social care services as necessary.

Boughton Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Boughton Medical Group

Boughton Medical Group is responsible for providing primary care services to approximately 12,362 patients. The practice is situated in Hoole Lane, Boughton in Chester. The practice is based in an area with lower than average levels of economic deprivation when compared to other practices nationally. The number of patients with a long standing health condition is about average when compared to other practices nationally. The practice has a large working age population.

The staff team includes six partner GPs, one salaried GP, two advanced nurse practitioners, two nurse practitioners, three practice nurses, two health care assistants, practice manager, office manager and administration and reception staff. There are both male and female GPs. The nursing team and health care assistants are female.

The practice is open 8am to 6.30pm Monday to Friday. An extended hour's service for routine appointments and an out of hour's service are commissioned by West Cheshire CCG and provided by Cheshire and Wirral Partnership NHS Foundation Trust. Patient facilities are on the ground floor. The practice has a car park for on-site parking.

The practice has a General Medical Service (GMS) contract. The practice offers a range of enhanced services such as spirometry, nurse led diabetes insulin initiation, flu and shingles vaccinations, minor surgery and timely diagnosis of dementia.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions

Detailed findings

• 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)

Before our inspection we reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 18th October 2016. We reviewed all areas of the practice including the administrative areas. We sought views from patients face-to-face and reviewed CQC comment cards completed by patients. We spoke to clinical and non-clinical staff. We observed how staff handled patient information and spoke to patients. We explored how the GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

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 in place for reporting, recording and investigating significant events. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. All staff spoken with knew how to identify and report a significant event. The practice carried out an analysis of significant events and this also formed part of the GPs' individual revalidation process. We looked at a sample of significant events and found that action had been taken to improve safety in the practice where necessary.

The practice held staff meetings at which significant events were discussed in order to cascade any learning points. A log of significant events was maintained which enabled patterns and trends to be identified. A review of the action taken following significant events was documented to demonstrate that actions identified had been implemented.

There was a system in place to manage patient safety alerts that ensured all relevant staff received them and action taken was recorded.

Overview of safety systems and processes

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and procedures were accessible to all staff. The procedures clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A printed flowchart with telephone numbers was on display outlining the process of making a child and adult safeguarding referral. There was a lead member of staff for safeguarding. The practice had systems in place to monitor and respond to requests for attendance/reports at safeguarding meetings. Staff demonstrated they understood their responsibilities and all had received safeguarding children training relevant to their role. The safeguarding lead GP liaised with the school health team, midwives and health visiting service to discuss any concerns about children and their families and how they could be best supported. Alerts were placed on patient records to identify if there were any safety concerns. We noted that the use of major alerts to highlight vulnerable patients should be reviewed to ensure these concerns were easily identifiable when reviewing records. Following our inspection we were provided with revised protocols to address this.
- A notice was displayed in the waiting room and in all treatment rooms, advising patients that a chaperone was available if required. All staff who acted as chaperones had received training for this role. A Disclosure and Barring Service (DBS) check had been undertaken for all staff who acted as chaperones. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead and they liaised with the local infection prevention teams to keep up to date with best practice. There were infection control protocols in place and staff had received up to date training. Infection control audits were undertaken by the infection control lead and action plans drawn up in response to any shortfalls identified. There was also a system to liaise with the management team to ensure actions identified were addressed.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing 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. We identified an area of good practice which was the quarterly review of blank prescription use. Vaccines were securely stored, were in date and we saw the fridges were checked daily to ensure the temperature was within the required range for the safe storage of vaccines. A minimum and a maximum temperature recording was not made which would allow the temperature to be monitored over a period of time. Following our visit the practice manager confirmed that the staff with this responsibility had been instructed to ensure this information was recorded and a check that this was taking place would be undertaken.

Good

Are services safe?

- There was a system in place to monitor uncollected prescriptions. We noted that the system to ensure high risk and vulnerable patients who did not collect prescriptions were identified was not recorded in the protocol for the management of prescriptions. A revised protocol was provided following the inspection. We also found that cautery probes had been removed from their original packaging so the use by date and manufacturers' instructions were not identifiable. Following the inspection we were provided with photographic confirmation that this had been addressed.
- We reviewed four personnel files of staff employed within the last two years 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 (DBS). A system was in place to carry out periodic checks of the Performers List, General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to ensure the continued suitability of staff. A DBS check had been undertaken for all clinical and non-clinical staff. We reviewed the records of three self-employed GP locums. We found that not all the required recruitment information was retained on their records. This was addressed during the inspection.

Monitoring risks to patients

- 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 displayed for staff to refer to. The practice had an up to date fire risk assessment and regular checks were made of fire safety equipment. A fire drill took place every 12 months. 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 also had a variety of other risk assessments in place to monitor the safety of the premises such as control of substances hazardous to health and legionella.
- Arrangements were in place for planning and monitoring the number and mix of staff needed. Staffing capacity was assessed bi-annually to ensure it met the needs of patients. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with 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 had up to date basic life support training. The practice had a defibrillator and oxygen available on the premises which was checked to ensure it was safe for use. There were emergency medicines available which were all in date, regularly checked and held securely.

The practice had a business continuity plan in place 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

Clinical staff we spoke with told us they used best practice guidelines to inform their practice and they had access to National Institute for Health and Care Excellence (NICE) guidelines on their computers. Clinical staff attended training and educational events provided by the Clinical Commissioning Group (CCG). GPs we spoke with confirmed they used national standards for the referral of patients for tests for health conditions, for example patients with suspected cancers were referred to hospital via a system which ensured an appointment was provided within two weeks. Reviews took place of prescribing practices to ensure that patients were provided with the most appropriate medications.

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. Current results (data from 2014-2015) showed the practice had achieved 99% of the total number of points available which was comparable to local (96%) and national (95%) averages. The practice had a 16.8% exception reporting rate in the clinical domain (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) which was above the CCG (8%) and national (9%) averages. We discussed this with the GP partners who reported that staffing changes and absences had resulted in high exception reporting. We were shown an analysis of current performance that indicated the practice was performing in line with local and national averages.

Data from QOF 2014-2015 showed that outcomes were comparable to other practices locally and nationally:

- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less was 80% compared to the CCG average of 84% and the national average of 84%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months was 73% compared to the CCG average of 73% and the national average of 75%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 moll/l or less was 89% compared to the CCG average of 83% and the national average of 81%.
- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 92% compared to the CCG average of 89% and the national average of 88%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 84% compared to the CCG average of 89% and the national average of 90%.

We saw that audits of clinical practice were undertaken. Examples of audits included audits of medication such as antibiotic prescribing and an audit of patients prescribed amiodarone (a medication used for many serious arrhythmias of the heart) audits of cytology and minor surgery. The audits showed changes had been made to practice where this was appropriate.

The GPs and nursing team had key roles in monitoring and improving outcomes for patients. These roles included the management of long term conditions, palliative care, safeguarding and promoting the health care needs of patients with a learning disability and those with poor mental health. The clinical staff we spoke with told us they kept their training up to date in their specialist areas. This meant that they were able to focus on specific conditions and provide patients with regular support based on up to date information.

Staff worked with other health and social care services to meet patients' needs. The practice had monthly multi-disciplinary meetings to discuss the needs of patients with complex and palliative care needs. These meetings ensured that patients' needs were communicated and coordinated across the various healthcare professionals involved in the patients care. Meetings were held with the health visiting service to review the needs of children where concerns had been identified. Contact was also made with

Good

Are services effective?

(for example, treatment is effective)

the school nurses and midwives if there were any concerns or if the practice required further information. An annual safeguarding meeting was carried out at the practice where the health visitors, midwives and school nurses attended.

Effective staffing

Staff had the skills, knowledge and experience 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.
- Locum GPs were provided with information they needed for their role and a locum pack was in place providing written information and sign posting to support this.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, those carrying out cytology and immunisations.
- 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. 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. There was a system in place to identify staff training needs and a plan in place to ensure training was updated.

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff through the practice's patient record system and their intranet system. This included assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. There were systems in place to ensure relevant information was shared with other services in a timely way, for example when people were referred to other services and the out of hours services.

Consent to care and treatment

We spoke with clinical staff about patients' consent to care and treatment and found this was sought in line with legislation and guidance. Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Patients applying for power of attorney were offered a 30 minute GP consultation. The practice also carried out Court of Protection assessments when requested for patients who lacked capacity. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Consent forms for surgical procedures were used and scanned in to medical records. Written guidance was available about consent to care and treatment. Some clinical staff had not received formal training on the Mental Capacity Act 2005 and the practice manager had scheduled dates for this training to take place.

Supporting patients to live healthier lives

New patients completed a health questionnaire and were asked to attend a health assessment with the practice nurse. Patients with complex medical needs and those who required medication were offered an appointment with a GP. The practice offered national screening programmes, vaccination programmes, children's immunisations and long term condition reviews. Health promotion information was available in the reception area and on the website. The practice had links with health promotion services and recommended these to patients, for example, smoking cessation, alcohol services, weight loss programmes and exercise services.

The practice monitored how it performed in relation to health promotion. It used the information from the QOF and other sources to identify where improvements were needed and to take action. QOF information for the period of April 2014 to March 2015 showed outcomes relating to health promotion and ill health prevention initiatives for the practice were comparable to other practices nationally. The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of

Good

Are services effective?

(for example, treatment is effective)

82% and the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening and wrote to patients who did not attend to encourage them to do so. The practice had been part of a pilot project with NHS England and Public Health England in January 2016 to increase bowel cancer screening rates. The aim was to increase uptake in the eligible patient population by 5%. The practice achieved 11% and continued to see an increase in the number of patients being screened.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages and in some instances above national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 87% to 99% compared to the CCG rates which ranged from 93% to 98% and the national rates which ranged from 73% to 95%. There was a system to ensure that any missed immunisations were followed up with parents or the health visitor.

The practice referred patients with a long term condition to Self-Management UK who provided a free six week course for patients to help them manage the day to day impact of living with a long term condition. These courses were run by people with experience of a long term condition. Twenty six patients had engaged with this service so far and feedback indicated that they had found this beneficial.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations to promote privacy. Patients who were distressed or who wanted to talk to reception staff in private were offered a private room to discuss their needs.

We received 13 comment cards and spoke to eight patients. Patients indicated that their privacy and dignity were promoted and they were treated with care and compassion. A number of comments made showed that patients felt a very good service was provided and that clinical and reception staff were dedicated, professional and listened to their concerns.

Data from the National GP Patient Survey July 2016 (data collected from July-September 2015 and January-March 2016) showed that patients responses about whether they were treated with respect and in a compassionate manner by clinical and reception staff were comparable to local and national averages for example:

- 91% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 96% said the nurse was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 95% said the nurse gave them enough time compared to the CCG average of 94% and national average of 92%.
- 97% said they had confidence and trust in the last nurse they saw compared to the CCG average of 98% and national average of 97%.

The practice was aware of the patient feedback from the National GP Patient Survey and the partners, practice manager and patient participation Group (PPG) had met to look at the performance of the practice and how any issues raised could be addressed. The PPG had also carried out an in-house survey in October 2015 which was responded to by 371 patients and showed positive patient feedback relating to care and treatment.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt health issues were discussed with them. They also felt listened to and involved in decision making about the care and treatment they received.

Data from the National GP Patient Survey July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were comparable to local and national averages, for example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 82%.
- 93% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- 88% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care. For example, support was provided to patients with communication needs relating to disability or sensory loss. Information leaflets and correspondence were available in different formats and print sizes on request. The practice had a hearing loop at reception and a portable loop was available to assist patients. Interpreters (including sign language) could be pre-booked to provide support during a consultation.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

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 referred patients who were over 18 and with long term health conditions to a well-being co-ordinator for support with social issues that were having a detrimental impact upon their lives.

Written information was available to direct carers to the various avenues of support available to them. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 244 (approximately 2%) of patients as carers which was above the CCG average of 1%. Patients were encouraged to complete carers forms so they were able to access services provided by the Carers Trust , for example, advice and information about money and benefits, practical help and emotional support. The practice had two carers links who were working to identify further carers to ensure they had access to the support services available. Major alerts were added to patient's records so staff were aware the patient was a carer to ensure flexibility was given around appointments.

Clinical staff referred patients on to counselling services for emotional support, for example, following bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area. For example**,** the practice offered a range of enhanced services such as spirometry, nurse led diabetes insulin initiation, flu and shingles vaccinations, minor surgery and timely diagnosis of dementia.

The practice had multi-disciplinary meetings to discuss the needs of young children, palliative care patients and patients with complex needs.

Two nurses from the practice had undertaken a study between 2012 and 2014 with the aim of assessing the effectiveness of early diagnosis of dementia and how this impacts on individuals and carers. The conclusions and recommendations included reducing waiting times for diagnosis and that the benefits of earlier diagnosis should continue to be promoted. As a consequence of the findings the practice had been involved in and developed services. Opportunistic screening for dementia took place. Following on from this the practice also offered an in-house dementia care assessment led by a nurse. This involved a 30 minute assessment of the patient and symptoms, followed by a memory assessment. If further investigations were needed the patient was referred on to specialist services. The practice had been part of the nurse led Vulnerable Housebound Adult Service pilot. The aim of this pilot was to improve the experience and outcomes for housebound, vulnerable, frail and elderly patients by advanced care planning and management. Dementia screening and review was included within this service provision. This included a full holistic assessment, an assessment of the patient's carer to ensure they were receiving sufficient support and sign posting for support service services and referrals to health and social care services as necessary.

Services were planned and delivered to take into account the needs of different patient groups. For example;

- The practice was open from 8am to 6:30pm Monday to Friday allowing early morning and evening appointments to be offered to working patients.
- Urgent access appointments were available for children and for any patients with medical needs that required a same day consultation.
- An express clinic to deal with minor and acute illness was run by an advanced nurse practitioner/nurse practitioner who had appointments available throughout the day.
- Home visits were made to patients who were housebound or too ill to attend the practice.
- A daily pre-bookable phlebotomy service was run by the practice.
- There were longer appointments available for patients, for example patients with a long term condition and patients experiencing poor mental health.
- The practice offered mid-week and Saturday flu vaccination clinics throughout September and October annually to encourage patients to access this service.
- The practice had an acute visiting service and GPs worked alongside the North West Ambulance Service to ensure patients were appropriately admitted to hospital and if not necessary received an assessment to meet their health needs.
- The practice offered annual reviews to patients who have had a splenectomy and to patients who had been diagnosed with coeliac disease. These reviews were in addition to the contractual requirements of the practice as the importance of these reviews had been identified for promoting patients' wellbeing. These patients were offered a review with the nursing team and immunisations in accordance with current guidelines.
- Nurses followed up patients who had an unplanned hospital admission to assess which services the patient needed such as a GP appointment or referral to health or social care services. The nurse also assessed whether the admission could have been avoided to help avoid further inappropriate admissions.
- Travel advice, NHS and non-NHS vaccinations were provided including yellow fever and anti-Malarial medication could also be prescribed.
- Translation services and an audio hearing loop were available if needed.
- A disability access audit had been undertaken and an action plan developed. As a result the practice had already made several changes to the premises including the provision of sliding electric doors, designated room for patients using wheelchairs to receive flu vaccinations and a baby change unit had also been fitted at a height suitable for wheelchair users.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The staff had received training in dementia awareness to assist them in identifying patients who may need extra support. Dementia friendly colours had been used on toilet doors and dementia friendly signage displayed to assist patients.
- The practice referred patients who were over 18 and with long term health conditions to a well-being co-ordinator for support with social issues that were having a detrimental impact upon their lives
- Reception staff sign posted patients to local resources such as Pharmacy First (local pharmacies providing advice and possibly reducing the need to see a GP) and Physio First which provided physiotherapy appointments for patients without the need to see a GP for a referral. The practice had produced very clear guidelines for reception staff to follow when guiding patients to the most appropriate health care services.
- The practice referred older patients to tea parties set up by a local supermarket. These were established to tackle social isolation in patients who live alone with limited support.
- The practice had an 'Assistance Dogs Policy' which ensured that any patient who had an assistance dog did not face any barriers or difficulties when attending the practice.
- A quarterly patient newsletter was also available which provided useful information to patients on the services offered at the practice and in the wider community.
- The practice told us about several community engagement projects they had been involved with in the last two years. Members of the clinical and management team collaborated with a local supermarket to deliver lifestyle advice and carry out patient health checks such as cholesterol and blood pressure checks in a specially adapted vehicle owned by the supermarket and located in its car park. The practice team visited a local pre-school to explain to children about what to expect when visiting their GP. The practice also commissioned artwork for the waiting room from a local primary school. The practice participated in the Great Boughton Healthy Living Day, a local community event that the practice set up with another local practice. A nurse and a receptionist attended this event and provided information about the services offered by the practice and delivered general health advice including height and weight measurement and blood pressure checks. The practice also liaised with a local college and provided posters, new patient packs and information about how to register with the practice and services offered for the Fresher's Fayre.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday allowing early morning and evening appointments to be offered to working patients. Patients could book appointments in person, via the telephone and some appointments could be booked on-line. Repeat prescriptions could be ordered on-line or by attending the practice. Appointments could be booked up to two weeks in advance. In addition to GP appointments being available to book online, nurse practitioner appointments and phlebotomy appointments were also bookable online for up to four weeks in advance. Pre-bookable telephone consultations with GPs, the advanced nurse practitioner and nurse practitioners were offered. The practice also offered a daily nurse advice line. This was available for all patients who required advice such as medication queries. This service was also used to contact patients who were requesting a home visit and to assess if this was the most appropriate outcome for the patient. A text messaging service reminded patients about their appointments, requested information from patients to assist in their care such as up to date blood pressure readings and reminded patients about services provided such as the flu vaccination.

An extended hour's service for routine appointments and an out of hour's service were commissioned by West Cheshire CCG and provided by Cheshire and Wirral Partnership NHS Foundation Trust.

The practice reviewed access to the service to ensure it met the needs of patients. For example, in order to reduce the numbers of missed appointments the practice had introduced a text messaging appointment reminder service. In order to promote the use of electronic technology when making appointments the practice had worked with the Patient Participation Group (PPG) to encourage patients to access locally based computer skills training.

The practice was also piloting eConsult. This service allowed patients (18+) who were registered at the practice to consult with a GP electronically and offered alternatives

Good

Are services responsive to people's needs?

(for example, to feedback?)

to telephoning and visiting the practice for common conditions and minor ailments. Patients were able to access self-help information, the Pharmacy First service, symptom checkers and NHS 111. An online questionnaire was submitted to a clinician and the practice contacted the patient with feedback by the end of the next working day. The benefits of this system included improved access and improved health outcomes through earlier detection of significant symptoms and earlier intervention. There was a good skill mix of staff to also promote good access to the service.

An annual appointment analysis was carried out to ensure that patients were being booked in to see the most appropriate clinician. The analysis enabled the practice to highlight any training needs and also ensured that all services were being signposted correctly.

The practice had been identified as a beacon practice for on-line patient access by NHS England. This involved sharing resources and implementation advice and guidance with all Cheshire and Merseyside GP practices. The practice manager actively liaised with other practices and offered NHS England and the Royal College of General Practitioners feedback on their supporting resources. The practice produced a case study and a YouTube video on their experience of implementing on-line patient access and this had been promoted nationally and showcased at the UK e-Health week in April 2016. The practice continued to support NHS England, for example the lead GP for information technology gave a presentation on "Online Access to Records: How does it work in Practice? at the Health Expo Conference in Manchester. This was to provide the audience with information about the practice's experience of implementing on-line patient access.

The practice offered patient access to records and they were promoting this to patients with a long term condition. This access can assist in empowering patients to manage their conditions and improve patients' health by providing self-care tools.

Results from the National GP Patient Survey from July 2016 (data collected from July-September 2015 and January-March 2016) showed that patient's satisfaction with access to care and treatment were above or comparable to local and national averages. For example:

- 81% of patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 73%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and national average of 85%.
- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 76%.
- 78% patients described their experience of making an appointment as good compared to the CCG average of 75% and national average of 73%.
- 92% of patients found the receptionists at this surgery helpful compared to the CCG average of 86% and national average of 87%.
- 67% of patients with a preferred GP said they usually get to see or speak to that GP compared to the CCG average of 58% and national average of 59%.

The practice was aware of the patient feedback from the National GP Patient Survey and the partners, practice manager and patient participation Group (PPG) had met to look at the performance of the practice and how any issues raised could be addressed. The PPG had also carried out an in-house survey in October 2015 which was responded to by 371 patients and showed positive patient feedback relating to access to healthcare.

We received 13 comment cards and spoke to eight patients. Patients said that they were able to get an urgent appointment when one was needed, that they were able to get through to the practice by phone easily and they were happy with the practice opening hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information about how to make a complaint was available for patients to refer to in the waiting room, in the patient information booklet and on the practice website. This included the details of who the patient should contact if they were unhappy with the outcome of their complaint.

The practice kept a record of written complaints. We reviewed a sample of four complaints received within the last 12 months. Records showed they had been

Good

Are services responsive to people's needs?

(for example, to feedback?)

investigated, patients informed of the outcome and action had been taken to improve practice where appropriate. A log of complaints was maintained which allowed for patterns and trends to be easily identified. The records showed openness and transparency with dealing with the complaints.

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

The practice had a statement of purpose which outlined its aims and objectives. These included providing the best quality care, ensuring all staff had the skills they need to competently carry out their roles and referring patients to other services when necessary. The practice also had a mission statement which was publicised on the practice website and in the waiting area:-

"We endeavour to deliver care in an efficient but empathic manner, maintaining the core principles and relationships of traditional general practice, whilst ensuring we engage with innovative and modern approaches to healthcare. Patients are at the heart of everything we do and we encourage patient empowerment and involvement in their own health."

The practice had developed core values for the delivery of the service:-

"Patients – Putting patients at the heart of everything we do and providing them with the tools and empowerment to manage their own health.

Quality – We provide high quality person-centred, safe and holistic care using evidence based practice.

Ethical – Operating within the ethical framework through openness and transparency.

Staff – We value every member of the practice team and demonstrate a commitment to personal development."

The staff team had been involved in developing the mission statement and core values. The staff we spoke with knew and understood the aims and objectives of the practice and their responsibilities in relation to these.

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.
- Audits were used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions.
- The practice worked in a cluster with three other practices to improve the services provided to their patients. A GP and the practice manager from Boughton Medical Group were the lead staff for the cluster with their roles being to drive and lead the cluster in monthly meetings and represent the cluster at meetings with the local Clinical Commissioning Group (CCG).
- Clinical staff were actively involved with the local CCG, Primary Care Cheshire and Local Medical Committee. For example, a nurse had until recently been the CCG lead for dementia and a GP was the vice-chair of the Local Medical Committee.
- The practice had won the West Cheshire CCG 2016 GP Practice of the Year Award and were finalists for the Nursing Team of the Year (General Practice Awards 2015) and finalists for the Service Innovation Team of the Year (General Practice Awards 2015).

Leadership and culture

The partners were visible in the practice and staff told us they 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).The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

There were clear lines of accountability at the practice. We spoke with clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or as they occurred with the practice manager, registered manager or a GP partner. Staff said they felt respected, valued and

Are services well-led?

Good

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

supported. All staff were 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.

Meetings took place to share information, look at what was working well and where any improvements needed to be made. The practice closed one afternoon per month which allowed for learning events and practice meetings. Clinical staff met to discuss new protocols, to review complex patient needs, keep up to date with best practice guidelines and review significant events. The reception and administrative staff met to discuss their roles and responsibilities and share information. The clinical staff also met informally on a weekly basis and the reception and administrative staff met bi-weekly which allowed any issues concerning the operation of the service to be discussed. The outcomes of meetings were shared across the various teams within the organisation. Partners and the practice manager met to look at the overall operation of the service and future development. We were shown a sample of meeting minutes and found that a comprehensive record was made that would allow for good information sharing.

We were informed that there was a focus on team events and incentives including a yearly profit sharing scheme. Team events were held to promote good working relationships, encourage staff performance and promote well-being.Team building events had included a cooking competition in a local restaurant, bowling, den building and a Hawaiian themed Summer BBQ. The practice had also run “Hero of the month” and competitions for all the team.

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 gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. A comment card box was also located in the waiting area.
- The PPG met every 6-8 weeks with full bi-annual PPG meetings with the practice. The chairperson met monthly with the practice manager. The PPG undertook patient surveys, were involved in supporting practice initiatives such as self-care week (promoting self-help tools and information) and annual flu clinics and submitted proposals for improvements to the practice management team. For example, the PPG had recommended that changes be made to the reception layout, patient check-in system, signage and the website. The practice had worked with the PPG to make the changes identified. The PPG members spoken with felt they were listened to and kept informed and consulted about changes and developments at the practice. The PPG linked up with other local PPGs to share ideas. The PPG described their achievements over the last 12-18 months which included establishing a walking group to support socially isolated patients and improve health. They had worked with the practice to promote on-line access to records which involved consultation about the process and developing marketing materials. They had set up a virtual PPG enabling email contact with patients who were unable to attend face to face meetings. This enabled patients to become involved in PPG discussions at a time convenient to them. The PPG had established links with a local high school to encourage young people to join the PPG. The practice and the PPG had also linked up with local services to provide computer training and set up email accounts to enable patients to use on-line access.
- The practice sought patient feedback by utilising the Friends and Family test. The NHS friends and family test (FFT)is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. The practice reviewed this feedback and discussed the results with the PPG.
- The results from all patient feedback, such as the National GP Patient Survey, Family and Friends Test and in-house surveys were analysed on a quarterly basis for any common themes. A You Said?We Did document was made available for patients and listed the common concerns raised by patients and the actions taken in response.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us

Are services well-led?

Good

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

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 strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice had been part of the nurse led Vulnerable Housebound Adult Service pilot were housebound patients were provided with an annual review of their dementia. This included a full holistic assessment, an assessment of the patient's carer to ensure they were receiving sufficient support and sign posting for support service services and referrals to health and social care services as necessary. The practice continuously reviewed the service to ensure it met the needs of patients. For example it had introduced eConsult a platform that enabled patients to self-manage and consult online with their own GP through their practice website. The benefits of this system included improved access and improved health outcomes through earlier detection of significant symptoms and earlier intervention. The practice also offered patient access to records and they were promoting this to patients with a long term condition. This access can assist in empowering patients to manage their conditions and improve patients' health by providing self-care tools.