Norwood Medical Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Norwood Medical Practice on 18 November 2015. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The NHS National GP Patient Survey of the practice showed high levels of patient satisfaction with the quality of GP and nurse consultations.
- Staff were committed to supporting patients to live healthier lives through a targeted and very proactive approach to health promotion.
- Risks to patients and staff were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- The practice was well equipped to treat patients and meet their needs.
- All staff were actively engaged in activities to monitor and improve quality and outcomes for patients.
- Information about how to complain was available and easy to understand.
- Very good arrangements had been made to meet the needs of patients who were also carers.
- Patient feedback about access to the practice and appointments was mixed. Whilst some patients were satisfied with access, the NHS GP Patient Survey results showed lower levels of satisfaction than the local Clinical Commissioning Group and national averages. The practice had taken steps to address this by making changes to their appointment system and how they met patients' needs.
- The leadership, governance and culture at the practice were used to drive and improve the delivery of

Summary of findings

high-quality person-centred care. There was a clear leadership structure and staff felt supported by the management team. Very good governance arrangements were in place.

- The practice had a clear vision for the development of the practice and safety as its top priority. The strategy and supporting objectives were stretching and challenging, whilst remaining achievable. Staff were committed to providing their patients with good quality care.

We also saw areas of outstanding practice:

- There were very good arrangements for meeting the needs of patients who required dermatological care and treatment. The senior GP partner acted as a GP with a Special Interest, and had set up a local community dermatology clinic at the practice. 220 patients had received care and treatment at the clinic during 2014/15. All patients, including those not registered with the practice, were seen and treated within three weeks of being referred to the clinic. Of these 514 patients, 53 had been diagnosed with skin cancer and, where relevant, an appropriate referral had been made to specialist services. This is outstanding because the practice is providing an additional service which reduces the burden on hospital services and enables patients to receive care and treatment closer to home.
- The practice demonstrated a very caring and responsive approach to patients and their individual needs. They had a dedicated member of staff in a patient liaison adviser (PLA) role, who was available, at all times the practice was open, to offer practical and emotional support to patients, and to advocate on their behalf with other agencies and support groups. On average, the PLA provided assistance to at least two patients every week. This is outstanding because it showed a strong commitment to helping patients who are facing emotional and practical challenges in their lives.
- Overall, there were very good arrangements for meeting the needs of patients diagnosed with dementia. The practice had designated clinical dementia leads who had worked with the rest of the team to improve their performance regarding the early diagnosis of dementia. Patients identified as being at risk of developing dementia were contacted by telephone and invited to make an appointment for their annual health care review. Where clinical staff had concerns about a patient's memory, allocated memory clinic appointments were also available at the practice. Clinicians were proactive in caring out dementia screening, where they thought patients were at risk of developing dementia. Several members of staff had completed the 'Dementia Friends' training course, to help them provide dementia patients with appropriate care and support.

However, there were also areas where the provider needs to make improvements. The provider should:

- GPs should carry emergency medicines for use on home visits in acute situations.
- Continue to review and improve the practice's telephone access and appointment system.
- Ensure that the guidance issued by NHS Protect regarding prescription security is followed.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

There were good arrangements for monitoring and managing risks to patient and staff safety. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement. There was an effective system for dealing with safety alerts and sharing these with staff. Individual risks to patients had been assessed and were well managed. Good medicines management systems and processes were in place and staff recruitment was safe. The premises were clean and hygienic and there were good infection control processes.

Are services effective?

Good

The practice is rated as good for providing effective services.

Outcomes for patients were consistently very good. The Quality and Outcomes Framework (QOF) data, for 2014/15, showed the practice had performed very well in obtaining 97.7% of the total points available to them, for providing recommended care and treatment to their patients. (This was 0.9% above the local clinical commissioning group (CCG) average and 4.2% above the England average. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health, and providing advice and support to patients to help them manage their health and wellbeing. Staff worked with other health and social care professionals to help ensure patients' needs were met. All staff were actively engaged in monitoring and improving quality and outcomes for patients. Staff were committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. Staff had completed a range of clinical audits and used these to improve patient outcomes.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

The feedback received from patients was positive about the way staff treated them. Results from the NHS GP Patient Survey of the practice showed patient satisfaction levels with the quality of GP and nurse consultations were very good and mostly above the local CCG and national averages. For example, of the patients who completed the survey, 97% said they had confidence and trust in the

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last GP they saw, compared to the local CCG average of 96% and the national average of 95%. However, the number of patients who found the receptionists helpful was less than the local CCG and national averages. Information for patients about the services provided by the practice was easily accessible and easy to understand.

The practice demonstrated a very caring and responsive approach to patients and their individual needs. They had a dedicated member of staff in a patient liaison adviser (PLA) role, who was available, at all times the practice was open, to offer practical and emotional support to patients, and to advocate on their behalf with other agencies and support groups. Good information about the role of the PLA was available within the practice. They also supported the patient participation group by attending their meetings. The practice kept a register of patients who were also carers. Their clinical system alerted clinical staff about patients who were also carers, so this could be taken into account when planning their care and treatment. Written information was available for carers to ensure they understood the various avenues of support available to them.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

Patients' individual needs were central to the planning and delivery of tailored services. Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and ensure continuity of care. In addition, staff helped to coordinate patients' care and treatment through partnership working with other services and providers. The practice actively engaged with the local CCG and worked with them to improve and develop patient care, in the locality within which they were based. Patient feedback about telephone access to the practice and appointments was mixed. Although the patients we spoke to were satisfied with telephone access to the practice and the appointment system, the results of the NHS GP Patient Survey of the practice showed lower levels of satisfaction than the local CCG and national averages. The practice was able to demonstrate that they had responded positively to this feedback, and had introduced changes to improve patients' experience of accessing appointments. The practice had good facilities and was well equipped to treat patients and meet their needs. Staff were clear about the improvements they wanted to make to the premises and were taking steps to achieve this. Information about how to complain was available and easy to understand, and evidence showed that the practice responded quickly to any issues raised.

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Are services well-led?

Outstanding 

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

The practice had a clear vision for the development of the practice and safety as its top priority. Staff were committed to providing their patients with good quality care. There was a proactive approach to developing new ways of providing care and treatment. This was clearly evident in the development of the practice's community based, dermatological community clinic. Governance and performance arrangements were proactively reviewed and reflected best practice, and these were underpinned by a comprehensive range of policies and procedures that were accessible to all staff. Staff had also achieved the Royal College of General Practitioners Practice Accreditation Award. In order to achieve this accreditation, a practice has to demonstrate a good standard of organisational practice, shared learning and quality improvement. There were highly effective systems and processes in place to identify and monitor risks to patients and staff, and to monitor the quality of services provided. Regular practice and multi-disciplinary team meetings took place, which helped to ensure patients received effective and safe clinical care. The practice proactively sought feedback from patients. They had an active patient participation group (PPG) whose members were encouraged and supported to comment on how services were delivered. There were high levels of staff satisfaction, and staff were very proud to work for the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. There are aspects of the practice that are outstanding which therefore impact on all population groups.

Nationally reported data showed the practice had performed well in providing recommended care and treatment for the clinical conditions commonly associated with this population group. For example, the practice had achieved 100% of the total Quality and Outcome Framework (QOF) points available to them, for providing recommended clinical care to patients who had cancer. This was 0.2% above the local CCG average and 2.1% above the England average. Good arrangements were in place for managing the needs of older patients. Patients aged 75 years and over had been allocated a named GP to help ensure their needs were met. The way clinical staff carried out home visits prioritised older patients with the most urgent needs and helped to reduce patient waiting times. It also helped to promote greater patient choice regarding when they were visited. The practice's clinical records system was used to 'flag' patients with mobility issues, so that reception staff would be reminded to offer them a ground floor consultation room. Telephone ordering of prescriptions was made available to older patients who might experience difficulties with the usual systems for doing this. Staff were able to make information available in large print to help older patients understand the services available to them.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions. There are aspects of the practice that are outstanding which therefore impact on all population groups.

Nationally reported data showed the practice had performed well in providing recommended care and treatment, for the clinical conditions commonly associated with this population group. For example, the practice had achieved 100% of the total QOF points available to them for providing recommended clinical care to patients who had chronic obstructive pulmonary disease. This was 2.4% above the local CCG average and 4% above the England average.

Very effective systems were in place which helped ensure patients with long-term conditions received an appropriate service which met their needs. Patients at risk of emergency hospital admissions were identified as a priority, and steps had been taken to manage

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their needs. Arrangements had been made to follow up these patients when they were discharged from hospital, or if they had had contact with the local out-of-hours service provider. Staff worked in partnership with local Case manager and Care Navigator staff to support patients they had judged were at risk of crisis and losing their independence, so they could access suitable sources of help. The practice used the 'Year of Care' approach as their model for providing personalised care to this group of patients. This approach had helped to promote patients' involvement in managing their long-term conditions. It had also helped to reduce the number of times patients with more than one long-term condition needed to visit the practice.

Staff used their skills, competence and experience to deliver more efficient and coordinated care to the patients. Staff had completed the training they needed to provide patients with safe care.

There were very good arrangements for meeting the needs of patients who required dermatological care and treatment. The senior GP partner acted as a GP with a Special Interest, and had set up a local community dermatology clinic at the practice.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There are aspects of the practice that are outstanding which therefore impact on all population groups.

Nationally reported data showed the practice had performed well in providing recommended care and treatment for this group of patients. For example, the QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them for providing contraceptive services. This was 3.2% above the local CCG average and 3.9% above the England average. Staff provided a range of services for families and younger patients, including family planning and contraceptive advice. The practice had a same-day care protocol, which prioritised parents contacting the practice about a young child. Staff had received training in how to implement this. The parent of any child who failed to attend a planned appointment, or who had been admitted into hospital from an asthma attack, received a follow up telephone call from practice staff. The practice offered a full childhood immunisation programme, and new mothers were able to access Well Baby clinics and a six week baby check.

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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). There are aspects of the practice that are outstanding which therefore impact on all population groups.

Nationally reported data showed the practice had performed well in providing recommended care and treatment for this group of patients. For example, the QOF data, for 2014/15, showed the practice had obtained 100% of the overall points available to them for providing care and treatment to patients who had hypertension. This was 1.1% above the local CCG average and 2.2% above the England average. The practice had assessed the needs of this group of patients and developed their services to help ensure they received a service which was accessible, flexible and provided continuity of care. The practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs of this group of patients. Extended hours GP and nurse appointments were offered to make it easier for working patients to access appointments.

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. There are aspects of the practice that are outstanding which therefore impact on all population groups.

There were good arrangements for identifying and meeting the needs of vulnerable patients, and for ensuring continuity of contact with them. The practice had a very detailed and comprehensive strategy that set out how staff should identify and meet the needs of vulnerable patients. We saw evidence which confirmed the practice enacted their strategy and regularly reviewed it to make sure it was effective and responsive. Alerts were added to patients' medical records so that all staff were aware of their vulnerability. Clinical staff held regular multidisciplinary meetings, which were used to discuss the needs of vulnerable patients. There were systems which supported clinical staff's understanding of the risks to their vulnerable patients. There was a good system in place for handling, prioritising and escalating incoming information about patients who had cancer, and end of life needs.

Lead clinical staff had been identified for patients with learning disabilities. They regularly liaised with the local community learning disability team to ensure they were kept up-to-date about patients' needs. There were longer appointments available for patients with learning disabilities and annual health checks were also offered. The

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practice had produced information in an appropriate format for this group of patients, to help them understand the services available to them. All staff had completed training in how to meet the needs of patients with learning disabilities.

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). There are aspects of the practice that are outstanding which therefore impact on all population groups.

There were good arrangements for meeting the needs of patients with mental health needs. The QOF data, for 2014/15, showed the practice had performed well by obtaining 100% of the overall points available to them for providing recommended care and treatment to patients with mental health needs. This was 4.6% above the local CCG average and 7.2% above the England average. Patients with mental health needs were offered an annual health review and were provided with advice about how to access various support groups and voluntary organisations. They were also able to access 'talking therapies' which help meet the needs of patients with a range of mental health problems. Arrangements were in place to follow up any patients with mental health needs who failed to attend a planned appointment. Examples of responsive care included inviting patients to attend a consultation following a long period of in-patient hospital care, and proactively reviewing the needs of any new patient registering with the practice who had a significant psychiatric history. Staff had also recently attended a dementia prescribing update to keep up-to-date with new guidance. Several members of staff had completed the 'Dementia Friends' training course, to help them provide dementia patients with appropriate care and support.

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What people who use the service say

We spoke with four patients from the practice's patient participation group as part of the inspection. All of these patients were complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were caring and helpful. They also said they were treated with respect and dignity at all times, they were very happy with the appointments system and the premises were always kept clean and tidy. As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. However, we received no completed comment cards.

The results of the NHS GP Patient Survey of the practice, published in July 2015, showed their performance was above, or in line with, most of the local clinical commissioning group (CCG) and national averages. However, patient satisfaction levels with regards to telephone access to the practice and obtaining appointments, fell below the local CCG and the national averages. Of the patients who responded to the survey:

- 94% said their last appointment was convenient. This was in line with the local CCG average and above the national average of 92%.
- 97% said they had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%.
- 91% said the last GP they saw or spoke with was good at treating them with care and concern, compared to the local CCG average of 89% and the national average of 85%.
- 98% said the last GP they saw or spoke to was good at giving them enough time, compared to the local CCG average of 90% and the national average of 87%.
- 89% said the last GP they saw or spoke to was good at listening to them, compared to the local CCG average of 91% and the national average of 89%.
- 99% said they had confidence and trust in the last nurse they saw or spoke to, compared with the local CCG average of 98% and the national average of 97%.
- 96% said the last nurse they saw or spoke with was good at treating them with care and concern, compared to the local CCG average of 93% and the national average of 90%.

However, there were also areas were the practice's performance fell considerably below that of the local CCG and the national averages. Of the patients who responded to the survey:

- 73% said they found receptionists at the surgery helpful, compared to the local CCG average of 90% and the national average of 87%.
- 61% said they would recommend the surgery to someone new in the area, compared to the local CCG average of 80% and the national average of 78%.
- 52% said they found it easy to get through on the telephone, compared to the local CCG average of 80% and the national average of 73%.
- 49% said they usually get to see or speak to their preferred GP, compared to the local CCG average of 62% and the national average of 60%.
- 49% described their experience of making an appointment as good, compared with the local CCG average of 79% and the national average of 73%.

(324 surveys were sent out. There were 116 responses which was a response rate of 36%. This is 1.5% of the total practice population.)

Areas for improvement

Action the service SHOULD take to improve

- GPs should carry emergency medicines for use on home visits in acute situations.
- Continue to review and improve the practice's telephone access and appointment system.

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- Ensure that the guidance issued by NHS Protect regarding prescription security is followed.

Outstanding practice

- There were very good arrangements for meeting the needs of patients who required dermatological care and treatment. The senior GP partner acted as a GP with a Special Interest, and had set up a local community dermatology clinic at the practice. 220 patients had received care and treatment at the clinic during 2014/15. All patients, including those not registered with the practice, were seen and treated within three weeks of being referred to the clinic. Of these 514 patients, 53 had been diagnosed with skin cancer and, where relevant, an appropriate referral had been made to specialist services. This is outstanding because the practice is providing an additional service which reduces the burden on hospital services and enables patients to receive care and treatment closer to home.
- The practice demonstrated a very caring and responsive approach to patients and their individual needs. They had a dedicated member of staff in a patient liaison adviser (PLA) role, who was available, at all times the practice was open, to offer practical and emotional support to patients, and to advocate on their behalf with other agencies and support groups. On average, the PLA provided assistance to at least two patients every week. This is outstanding because it showed a strong commitment to helping patients who are facing emotional and practical challenges in their lives.
- Overall, there were very good arrangements for meeting the needs of patients diagnosed with dementia. The practice had designated clinical dementia leads who had worked with the rest of the team to improve their performance regarding the early diagnosis of dementia. Patients identified as being at risk of developing dementia were contacted by telephone and invited to make an appointment for their annual health care review. Where clinical staff had concerns about a patient's memory, allocated memory clinic appointments were also available at the practice. Clinicians were proactive in caring out dementia screening, where they thought patients were at risk of developing dementia.

Norwood Medical Centre

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.

Background to Norwood Medical Centre

Norwood Medical Practice is a busy town practice providing care and treatment to approximately 11044 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice is part of NHS Cumbria clinical commissioning group (CCG.) The practice is based in Barrow-in-Furness and we visited the following location as part of the inspection:

- 99 Abbey Road, Barrow-in-Furness, Cumbria. LA14 5ES.

The district within which the practice is located has the lowest life expectancy for males and females in Cumbria. The practice serves an area where deprivation is higher than the local CCG and England averages. The practice has a low proportion of patients from ethnic minorities, for example, only 1.1% of the population are Asian.

The practice is located in an adapted residential building and provides patients with mobility needs with access to some treatment and consultation rooms on the ground floor. The practice offers a range of chronic disease clinics as well as services aimed at promoting patients' health and wellbeing. There are seven GP partners (three male and four female), a managing partner, a deputy practice manager, a medicines support staff member, a patient liaison adviser, a clinical care co-ordinator and a team of administrative and reception staff. The practice also has a nurse practitioner and a team of five nurses (all female.)

The practice's core opening hours are Monday to Friday between 8am and 6pm. In addition, early morning and late evening extended hours appointments are also provided from: 6:30pm to 7:30pm on a Monday and Thursday evenings; 7am on a Tuesday morning; 7:30am on Wednesday, Thursday and Friday mornings. GP appointment times were available as follows:

Monday: 8am to 7:20pm.

Tuesday: 7:10am to 5:20pm.

Wednesday: 7:30am to 4pm.

Thursday: 7:30am to 7:20pm.

Friday: 7:30am to 4:40pm.

When the practice is closed patients can access out-of-hours care via the Cumbria Health On-Call service, and the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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. This inspection was planned to check whether the registered 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

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
- 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)

The inspection team:

- Reviewed information available to us from other organisations, for example, such as NHS England.
- Reviewed information from the CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 18 November 2015.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed and operated.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed a sample of the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach to reporting and recording significant events. All staff demonstrated a strong commitment to reporting incidents to help improve patient safety. The practice had a policy which described how staff should respond to and manage significant events. Staff had received training on significant events as part of their induction training, to help them recognise and report significant events and critical incidents. Staff were clear about how to report these and gave us examples of how they dealt with them. All incidents reported by staff were reviewed and categorised at the weekly clinical practice meetings. Where incidents were categorised as a significant event, we were told a second GP would review any relevant information. Significant events were also reviewed during the practice's quarterly patient safety and quality improvement meetings, to identify any recurring themes and to ensure that any relevant learning could take place. The sample of records we looked at showed critical incidents and significant events had been appropriately handled, and lessons learned by the team. Relevant significant events were shared with peers via the Practice Manager's Forum to help promote shared learning within the locality. We were told that, where appropriate, patients and, or, their carers would be invited to meet with staff, to discuss any issues or shortfalls in the quality of the service provided. Staff also used the local Safeguarding and Incident Management system to record and report concerns that had affected their patients to other agencies such as hospitals and the local clinical commissioning group (CCG).

Good arrangements were in place for managing patient safety alerts. Patient safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE.) All safety alerts received by the practice were initially reviewed and then distributed via email to relevant staff, to enable appropriate action to be taken. Key members of staff monitored this system to ensure all safety alerts were appropriately reviewed and, where necessary, actioned. All safety alerts were stored on the practice's shared drive, providing all staff with easy access to them. National pharmacy drug safety alerts were displayed in a central area within the practice, and information produced by the Area Prescribing Committee was reviewed and disseminated at quarterly patient safety and quality improvement meetings. Staff told us that any alerts with significant implications for clinical practice were discussed during the staff team's weekly clinical meetings.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe.

Arrangements had been made to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies. Staff had access to safeguarding policies, and information was available regarding which agencies should be contacted when there were safeguarding concerns. Staff were easily able to access these, as well as flowcharts which provided a clear and understandable outline of the practice's safeguarding processes. One of the GP partners acted as the designated safeguarding lead and provided colleagues with guidance and support whenever this was required. Minutes of team meetings provided evidence that, when potential weaknesses in the practice's safeguarding approach were identified, action was taken to learn from these and improvements were made. Staff demonstrated they understood their responsibilities to safeguard patients and all had received safeguarding training relevant to their role. This included Level 3 training in child protection for the GPs. There were arrangements for making sure that 'looked after' children were identified on the practice's clinical records system. There were good systems which ensured that children who failed to attend planned appointments and immunisations were followed up, to identify the reason for their non-attendance. For example, a letter was sent to the parents of children who failed to attend for their first six-week check, and the health visitor was copied into this.

Good chaperone arrangements were in place. A notice had been placed in each of the waiting rooms advising patients that staff would act as chaperones, if required. All staff who acted as a chaperone had undergone a Disclosure and Barring Service (DBS) check and had received chaperone training. (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.)

Good

Are services safe?

There were good arrangements for managing medicines, including emergency drugs, which kept patients safe. A member of the GP team acted as the prescribing lead for the locality. We were told this had benefited the practice greatly. For example, the prescribing lead was able to help other staff at the practice keep up to up-to-date with the latest prescribing guidance. The practice had taken good steps in relation to medicines optimisation (ensuring that the right patients get the right choice of medicine, at the right time), and used their prescribing data to monitor their prescribing. The local CCG data we looked at indicated that staff were prescribing within accepted parameters. Staff carried out regular medication audits, with the support of the local CCG pharmacy adviser, to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Evidence supplied to us by the practice showed prescribing costs had remained quite static over the previous six years even though clinicians had faced increased prescribing demands from patients and secondary care. In addition, with national growth for prescribing costs running at between 3% and 5% during this period of time, the practice's expenditure had stayed static against the trend of national increase.

There were good arrangements for making sure any changes to patients' medicines, made by other healthcare professionals, were identified and reviewed by a GP. All prescription pads and forms were kept secure. However, we identified that staff were not keeping a log of prescription pad serial numbers as required by national guidelines.

The arrangements for handling repeat prescriptions, and carrying out medicine reviews, were safe. Staff had carried out a recent audit to check whether patients receiving anti-depressant medication had received a medicines review, in line with the practice's policy. The practice had identified that some patients receiving this type of medication had not received a review. We saw that steps had been taken to address this, and a further audit was planned for January 2016 to see if planned improvements had been made. Suitable arrangements had been made to monitor patients prescribed 'high-risk' medicines.

There were good arrangements for handling vaccines. Vaccines were stored appropriately, and regular checks were carried out to make sure they were kept within the temperature range specified in national guidance.

There were effective arrangements for ensuring that only suitable staff were employed at the practice. The staff files we sampled showed that appropriate checks had been undertaken on the members of staff concerned, prior to their employment. These included: checks that staff were registered with the appropriate professional body; obtaining references from previous employers; checking that staff had obtained the qualifications they needed to carry out their roles and responsibilities; carrying out a DBS check to make sure, where appropriate, new staff were safe to care for vulnerable adults and children.

Appropriate standards of cleanliness and hygiene were being maintained. The practice was clean and tidy throughout. We saw evidence of a structured and managed approach to maintaining cleanliness within the practice, including guidance for staff to follow when carrying out deep cleaning. Some of the clinical rooms were carpeted which can make them difficult to keep clean. We were told an agreed programme was in place to replace the carpets with a more suitable floor covering, and we saw that the first room had already been completed.

There were up-to-date infection control protocols in place and the practice had a designated infection control clinical lead, who provided staff with guidance and advice when appropriate. This person had completed the advanced training they needed to enable them to carry out this lead role effectively. All staff had completed basic infection control awareness training.

Staff had produced an infection control annual statement in line with the requirements of the Department of Health Hygiene Code of Practice. Following the practice's last infection control audit, staff had made improvements which included carrying out an annual hand hygiene audit. A legionella risk assessment had been completed in 2013, and regular water temperature checks were undertaken to help prevent the risk of legionella developing in the practice's water systems. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.)

Monitoring risks to patients:

There were effective procedures in place for monitoring and managing risks to patient and staff safety. The practice had an up-to-date fire risk assessment and the most recent fire drill was carried out in October 2015. Eight staff had been trained as fire wardens. These staff worked in various areas of the building and this helped to ensure there was good cover, which was important given the complicated

Good

Are services safe?

layout of the premises. Work was underway to improve the practice's emergency lighting. All electrical and clinical equipment had been checked to ensure it was safe to use and in good working order. Staff had carried out a health and safety risk assessment in 2015, to help identify and minimise risks to staff and patients.

Good arrangements were in place for planning and monitoring the number and mix of staff required to meet patients' needs. There was a rota system for all the different staffing groups to ensure that enough staff were on duty at all times. There was minimal use of locum GP cover.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on all of the computers used by staff, which alerted them to any emergency occurring at the practice. All staff received annual basic life support training. However, we did identify that it was the practice's policy to only provide clinical staff with CPR training every 18 months, and to non-clinical staff every three years. The Resuscitation Council (UK) recommends that clinical and non-clinical staff should have annual updates.

Emergency medicines were available for use within the practice and these were stored securely. A system was in place for checking these medicines, and the sample we looked at were all within their expiry dates. The staff we spoke with knew where the emergency medicines were held. Staff also had access to a defibrillator and oxygen for use in an emergency. Regular checks had been carried out to make sure these were kept in good working order. Staff had recently carried out an audit, based on guidance produced by the Resuscitation Council UK, to make sure that the practice was following best practice guidelines regarding the management of emergency medicines and equipment. The practice had taken action to address the few shortfalls that had been identified. We were told during the inspection that GPs did not take emergency medicines with them when they carried out routine home visits. This meant that GPs carrying out a routine home visit would not have access to emergency medicines for use in an acute situation should this be required.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included the emergency contact numbers of staff. All staff had access to this document, which was kept on the practice's intranet system. In addition, key staff were able to access the continuity plan remotely.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including the National Institute for Health and Care Excellence (NICE) best practice guidelines, and national and regional care pathways. There was a structured process for making sure any new guidance received by the practice was reviewed, disseminated and implemented by the clinical team. This included using designated lead staff to review new guidance that related to their areas of responsibility. In addition to this, a nominated GP reviewed all NICE guidance coming into the practice, to make sure nothing was missed. We saw evidence that, as a minimum, outlines of significant changes to current guidance were disseminated at weekly clinical meetings. All NICE guidance was also reviewed at quarterly practice meetings. There was evidence that all staff benefitted from the contacts clinical staff had with other organisations and service providers. Clinical staff were able to access NICE and local guidelines via the practice's intranet system.

Management, monitoring and improving outcomes for people

Outcomes for patients were consistently good. The practice participated in the Quality and Outcomes Framework (QOF) scheme. (This is intended to improve the quality of general practice and reward good practice.) Staff used the information collected for the QOF, and their performance against national screening programmes, to monitor and improve outcomes for patients. The practice's clinical exception reporting rate at 11.9% for 2014/15, was slightly above the local CCG average, by 1.8%, and the England average, by 2.7%. The practice was aware of this, and told us they had a robust policy towards exception reporting which they always implemented. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect.)

The QOF data, for 2014/15, showed the practice had performed well in obtaining 97.7% of the total points available to them. (This was 0.9% above the local clinical commissioning group (CCG) average and 4.2% above the England average.) The data also showed the practice had obtained 99.2% of the total points available to them for delivering care and treatment aimed at improving public health. This achievement was 2% above the local CCG average and 3.5% above the England average. Examples of good QOF performance included the practice obtaining:

- 100% of the total points available to them for providing recommended clinical care for patients who had cancer. This was 0.2% above the local CCG average and 2.1% above the England average.
- 100% of the total points available to them for providing recommended clinical care for patients who had chronic obstructive pulmonary disease. This was 2.4% above the local CCG average and 4% above the England average.

We noted that there were two clinical indicators where the practice had not obtained all of the points available to them. The inspection team was not concerned about this after receiving further information from the practice.

Staff had carried out clinical audits to help improve patient outcomes. We found that the practice had a structured approach to planning and identifying topics for audit activity. For example, we were provided with audit timetables covering 2014/15 and 2015/16. These identified planned audit activity, who the lead member of staff was, over what period the audit would take place and dates of actual and expected completion.

We asked the practice to send us evidence that the quality of treatment they provided had been monitored within the last 12 months. In particular, we requested that they provide us with evidence of two-cycle audits that had been completed in the last 12 months, as well as a summary of any other audits they had completed during this period. Whilst the practice sent us a range of audit information, none of these consisted of two-cycle audits. However, during and shortly after our inspection, we were given examples of completed clinical audits. The audits we looked at focussed on important clinical topics and showed evidence of lessons learned. However, we think some of those we looked at could have been better set out so that patient improvements were easier to identify and compare.

Staff had carried out other audits to help ensure patients were receiving the care and treatment they needed to manage their health. For example, staff had

Good

Are services effective?

(for example, treatment is effective)

recently reviewed the needs of patients who had attended the local Accident and Emergency department on five or more occasions during a proscribed period of time. The aim of the review was to determine whether there was any further action that could be taken to reduce these attendances, for either these specific individuals, or the patient population in general. Similarly, staff had also audited the reasons why a small group of patients had been admitted into hospital in an emergency. Staff also undertook a range of annual audits to check that they were complying with best practice guidelines in areas such as child protection, control of infection, maintaining the 'cold-chain' for medicines requiring cold storage, emergency equipment and contraceptive implants.

Effective staffing

The practice ensured staff had the skills, knowledge and experience to deliver effective care and treatment. This included providing new staff with an induction. For example, there was an induction pack for locum GPs to help make sure they understood the practice's systems, policies and procedures. Staff had received the training they needed to carry out their roles and responsibilities, including for example, training on safeguarding vulnerable patients, basic life support and infection control. Staff had access to, and made good use of, e-learning training modules, in-house and external training. There were arrangements in place for staff to have an annual appraisal, and GP staff were supported to work towards their re-validation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped to make sure staff had the information they needed to plan and deliver effective patient care and treatment. The information included, for example, patients' medical records, test results and hospital discharge information. A good system was in place to help ensure there was a prompt response to incoming information, such as patient test results. For example, a 'buddy' system was operated to ensure that test results were reviewed and actioned in the absence of the patient's usual GP. These arrangements included the reception manager monitoring the number of patient test results that were pending.

All relevant information was shared with other services in a timely way. For example, when patients were referred to other services. One of the GPs was a member of the board of management of the local out-of-hours provider. They had used this experience to strengthen the practice's understanding of how this service operated, and to develop systems which 'dovetailed' with this service's patient care processes.

Staff worked well together, and with other health and social care professionals, to meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. The practice held regular multi-disciplinary team meetings involving other healthcare professionals. Staff told us this helped to ensure that information about the needs of vulnerable patients was effectively shared between practice and community based staff.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. They understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (2005). When staff provided care and treatment to children and young people, they also carried out assessments of their capacity to consent that were in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear, the GP or nurse assessed the patient's capacity and recorded the outcome of the assessment.

Health promotion and prevention

Staff were highly committed to supporting patients to live healthier lives through a targeted and proactive approach to health promotion. NHS patient information leaflets were available in the practice and were shared with patients to help them manage their long-term conditions. Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. The practice had a comprehensive screening programme. For example, nationally reported QOF data, for 2014/15, showed the practice had performed well by obtaining 100% of the overall points available to them for providing recommended care and treatment to patients who smoked. This was 3.1% above the local

Good

Are services effective?

(for example, treatment is effective)

CCG average and 4.9% above the England average. The data also confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy.

The QOF data also showed the practice had performed very well by obtaining 100% of the overall points available to them, for providing cervical screening services. This was 0.6% above the local CCG average and 2.4% above the England average. The data showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests. Publicly available data showed that 81.7% of women aged 25 or over had received a cervical screening test in the preceding five years. This was 2.5% above the local CCG average and 5% above the England average. In addition to letters sent out centrally to patients, inviting them to attend for a smear test, the practice also sent patients an additional two letters, and followed non-responders up with telephone call from a GP. The practice had also performed very well by obtaining 100% of the overall points available to them for providing contraceptive services to women during 2014/15. This was 3.2% above the local CCG average and 3.9% above the England average.

The practice offered a full range of immunisations for children at a weekly immunisation clinic. They had performed very well in delivering childhood immunisations. For example, the nationally reported data that was available to us showed that the immunisation rates for 15 of the 17 childhood immunisations were over 90% and three of the immunisations rates were 100%. (There was no data available for three of the childhood immunisations listed). Influenza vaccination rates for patients over 65 years of age, and for those patients in at risk groups, were comparable to the local CCG averages.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection we observed that members of staff were courteous and helpful to patients. Patients attending the practice, or calling by telephone, were treated with dignity and respect. Curtains or screens were provided in consulting rooms, so that patients' privacy and dignity could be maintained during examinations and treatments. Consultation and treatment room doors were closed during consultations, so that conversations taking place in these rooms could not be overheard. A member of the reception team told us patients would be offered access to a private space, if they wanted to discuss confidential matters.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. However, we did not receive any completed patient comment cards. We spoke with four members of the practice's patient participation group on the day of our inspection. They told us they were very satisfied with the care and treatment provided by the practice and said their dignity and privacy was respected at all times. They also told us they thought the GPs and nursing staff were very good at their jobs, and looked after them well.

Results from the NHS GP Patient Survey of the practice, published in July 2015, showed patients were satisfied with how they were treated by staff who worked at the practice. However, the number of patients who found the receptionists helpful was less than the local CCG and national averages. The practice was aware of this, and was committed to supporting their reception team to continue to develop and improve how they worked with patients. Patient satisfaction levels with the quality of GP and nurse consultations were mostly above the local CCG and national averages. Where this was not the case, patient satisfaction levels were either in line with, or just below, these averages. Of the patients who responded to the survey:

- 97% said they had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average of 95%.
- 89% said the GP was good at listening to them, compared to the CCG average of 91% and the national average of 89%.
- 98% said the GP gave them enough time, compared to the local CCG average of 90% and the national average of 87%.
- 91% said the last GP they spoke to was good at treating them with care and concern, compared to the local CCG average of 89% and the national average of 85%.
- 99% said they had confidence and trust in the last nurse they saw, compared to the local CCG average of 98% and the national average of 97%.
- 96% said the last nurse they spoke to was good at treating them with care and concern, compared with the local CCG average of 93% and the national average of 90%.
- 73% said they found the receptionists at the practice helpful, compared with the local CCG average of 90% and the national average of 87%.

At the time of the inspection, the practice had received 29 responses via the 'iWantGreatCare' website, which they used as their Friends and Family survey provider. The practice had received a rating of four stars out of five. The feedback the practice received about the quality of care and treatment patients received was mostly positive. For example, words used to describe the practice included: treated with dignity and empathy by all staff; excellent treatment in a very pleasant manner; extremely helpful; appointment conducted in a professional manner; professional, but friendly and approachable; timely care and helpful advice. However, a very small number of patients raised concerns about staff attitudes.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decisions 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 treatments available to them.

Results from the NHS GP Patient Survey of the practice showed patients responded positively to questions about

Are services caring?

their involvement in planning and making decisions about their care and treatment. The results were either above, or broadly in line with, local and national averages. For example, of the patients who responded to the survey:

- 93% said the last GP they saw was good at explaining tests and treatments; compared to the local CCG average of 89% and the national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care. This was in line with the local CCG average but above the national average of 81%.

Patient and carer support to cope emotionally with care and treatment

Good arrangements had been made to meet the needs of patients who were also carers. For example, the practice's website signposted these patients to local and national carers' organisations. Written information was also available for carers to ensure they understood the various avenues of support available to them. Staff kept a register of patients who were also carers and this helped them to identify and meet their specific needs. (At the time of the inspection, there were 190 patients on the register, which equated to 1.7% of the practice population.) On registering with the practice, new patients were asked whether they undertook caring responsibilities. A designated member of staff acted as a 'carers' champion' and patient liaison adviser (PLA.) (Champions are staff who have completed awareness training to enable them to provide in-depth knowledge and expertise in identifying supporting carers.) Posters in the patient waiting rooms informed patients how to access the practice's 'carers' champion' and PLA, as well as the local carers' support group. Business cards for the PLA were available in the reception and waiting areas, treatment and consultation rooms. The PLA had a direct telephone line to promote easy access for patients. Reception staff had been briefed that should a patient arrive in a distressed state, they should contact the PLA. The PLA attended the patient participation group and worked closely with its members to promote and action any suggestions made to improve patients' experience of the practice.

Good arrangements had been made to support bereaved patients. We were told that staff sent bereaved patients a sympathy card, which included reference to the 'In Your Loss' pack that was available at the practice. The managing partner told us this was followed up with a telephone call the following week, to ask the bereaved patients whether they wished to make an appointment. Posters available in the reception areas signposted patients to the various sources of support available to them.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients' individual needs were central to the planning and delivery of tailored services. Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and ensure continuity of care.

The practice had very good arrangements for identifying and meeting the needs of vulnerable patients, and for ensuring continuity of contact with them. Alerts were added to patients' medical records so that all staff were aware of their vulnerability. Staff held regular multi-disciplinary team meetings, which were used to discuss the needs of vulnerable patients. There were other arrangements which supported clinical staff in managing and meeting the needs of their vulnerable patients. For example, the practice had reached an agreement with local pharmacies that they would be notified when vulnerable patients failed to collect their repeat prescriptions. There was an effective system for handling, prioritising and escalating incoming information about patients who had cancer and, or, end of life needs. This included providing these patients with direct access to their preferred GP, or the on-call doctor. Flexible arrangements had been made to support the needs of patients undergoing dialysis, including offering more responsive appointments. Older patients who had experienced a fall had their needs reviewed by a GP, to determine what support they should be offered. Arrangements were in place to offer patients appropriate support in the event of a still birth or a traumatic miscarriage.

Patients with learning disabilities, and those with mental health needs, had access to care and treatment which had been planned to meet their needs. The practice kept a register to help ensure their staff knew who these patients were, so they could make arrangements to assess and meet their needs. Lead clinical staff had been identified, and they regularly liaised with the local community learning disability team, to ensure they were kept up-to-date about their patients' needs. Longer appointments were available for patients who had learning disabilities and annual health checks were also offered. The practice had produced information in an appropriate format for this group of patients, to help them understand the services available to them. Administrative staff, as well as clinical staff, had completed training in how to meet the needs of patients with learning disabilities.

Good arrangements were in place for managing the needs of older patients and patients with long-term conditions. In particular, the practice's clinical records system was used to 'flag' patients with mobility issues, so that reception staff would be reminded to offer them a ground floor consultation room. Minutes from a recent staff meeting indicated that staff were expected to vacate their room should a disabled patient need ground floor access for their appointment. Telephone ordering of prescriptions was available to older patients who might experience difficulties with the usual systems for doing this. Staff were able to make information available in large print, to help older patients understand the services available to them. In 2014, the practice made radical changes to the way GP staff carried out home visits. Each morning, a GP was allocated the responsibility of carrying out home visits. This had helped to reduce waiting times and offered patients who needed home visits greater choice, and GPs more flexibility when prioritising the order in which these visits would be made. Housebound patients had been 'flagged' on the practice's clinical IT system, so staff were aware of their needs.

Staff proactively assessed and managed the needs of patients with long-term, complex needs. They had used a local intelligence system to identify patients with complex medical and social needs, who were at greater risk of an emergency admission into hospital. Alerts had been added onto their medical records to alert staff to their needs. These patients had been offered a consultation with a member of the nursing team, to look at ways in which the practice could support them to avoid emergency hospital admissions.

Patients at risk of hospital admission were identified as a priority, and steps had been taken to manage their needs. Arrangements had been made to follow up these patients once they were discharged from hospital, or following any contact they had with the local out-of-hours service provider. Practice staff worked in partnership with the local Case manager and the Care Navigator to support patients judged to be at risk of crisis and losing their independence, so they could access suitable sources of help. The nurse practitioner, and a designated member of staff who acted

Are services responsive to people's needs?

(for example, to feedback?)

as a referrals coordinator, met fortnightly with the local 'Case Manager' and the 'Care Navigator'. They used these meetings to identify patients who would benefit from being referred to the local 'Case Manager' and the 'Care Navigator', and to obtain feedback on those who were already receiving the service. These arrangements helped to ensure that the practice's vulnerable patients received the extra support and care they required to stay safe and independent.

During the previous two years, clinical staff had completely reorganised how they met the needs of patients with long-term care needs. Staff had adopted the 'Year of Care' approach, as their model for providing personalised care to this group of patients. All patients received an initial appointment with a health care assistant in their birth month, so that any required tests could be carried out. Patients were then invited to attend a second appointment with a specialist nurse. This consultation focussed on promoting self-management and educating patients about their conditions. Arrangements were in place which ensured housebound patients with long-term conditions also received the same level of care and support. Staff told us they had adopted the 'Year of Care' model in part because it helped to ensure that patients with more than one long-term condition avoided being invited to attend multiple annual health reviews. A range of protocols and pathways were in place which supported staff to provide patients with a good level of care and treatment.

There were very good arrangements for meeting the needs of patients with dermatological care needs. The senior GP partner acted as a GP with a Special Interest in this field, and they had set up a local community dermatology clinic at the practice. Evidence provided to us, showed that 220 patients had received care and treatment at the clinic. All patients, including those not registered with the practice, were seen and treated within three weeks from referral to the clinic. Out of these514 patients, 53 had been diagnosed with skin cancer and, where relevant, an appropriate referral had been made to specialist services. The provision of this service had led to improved funding, which had in turn enabled the practice to increase the number of healthcare assistant hours available to support this service.

The QOF data, for 2014/15, showed the practice had performed well by obtaining 100% of the overall points available to them, for providing recommended care and treatment to patients with mental health needs. This was 4.6% above the local CCG average and 7.2% above the England average. Patients with mental health needs were offered an annual health review and were given advice about how to access various support groups and voluntary organisations. They were also able to access 'talking therapies' which offer help to patients with a range of mental health problems. Arrangements were in place to ensure patients with mental health needs, who had returned home following a long-term stay in hospital, were invited to attend a consultation after they were discharged from the hospital. Also, when the practice was notified that a patient had self-harmed, or attempted suicide, it was their policy to have a clinician immediately review their case records and offer them a 20 minute appointment to take place within 10 working days of the notification. Any new patient whose clinical records contained evidence of a significant psychiatric history, domestic violence or safeguarding concerns, would also have their needs reviewed by a GP, to determine what support could be offered.

The QOF data showed the practice had performed well by obtaining 100% of the overall points available to them, for providing recommended care and treatment to patients with dementia. This was 4.3% above the local CCG average and 5.5% above the England average. Of those patients who had dementia, 83.7% had received a face-to-face review of their needs during the preceding 12 months. The practice had designated clinical dementia leads who had worked with the rest of the team to improve their performance regarding the early diagnosis of dementia. Patients identified as being at risk of developing dementia were contacted by telephone and invited to make an appointment for their annual health care review. Where clinical staff had concerns about a patient's memory, allocated memory clinic appointments were also available at the practice. Clinicians were proactive in caring out dementia screening, where they thought patients were at risk of developing dementia. Arrangements were also in place to 'flag' these patients on the practice's clinical IT system, to help make sure staff knew who these people were. Arrangements had been made for the dementia nurse lead to attend a training programme on dementia detection and treatment. They had also recently attended a dementia prescribing update to keep up-to-date with new guidance. Several members of staff had completed the 'Dementia Friends' training course, to help them provide dementia patients with appropriate care and support.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Staff provided a range of services for families and younger patients, including family planning and contraceptive advice. Whenever possible, a small number of appointments were made available each afternoon for patients who were under 16 years of age. The practice had a same-day care protocol which prioritised parents who contacted the practice about a young child. Staff told us they had received training in how to deal with this type of request. There good arrangements for making sure that the parents of any child failing to attend an emergency appointment, or parents of children with asthma who had been admitted into hospital, received a follow up telephone call from practice staff. A full childhood immunisation programme was offered, and new mothers were able to access Well Baby clinics and a six week baby check. Immunisation clinics and child asthma reviews were scheduled at an appropriate time, to make sure children's school attendance was not affected.

Extended hours appointments were provided for working patients and students who could not attend during normal opening hours. Patients were able to book appointments and order repeat prescriptions on-line. Working age patients had access to a range of services, including NHS health checks, Well Man/Woman clinics and travel clinics.

The provision of a good website which offered patients access to a range of information to help them manage their own health and well-being. This included a video library providing information about common illnesses, including long-term conditions, and how to manage them.

Reasonable adjustments had been made which helped patients with disabilities and those whose first language was not English, to use the practice. For example, some of the consultation and treatment rooms were located on the ground floor. There were disabled toilets which had appropriate aids and adaptations. A loop system was available to help improve accessibility for hearing impaired patients, and a member of the staff team was fluent in sign language. The ground floor waiting area was spacious making it easier for patients in wheelchairs to manoeuvre. Wheelchair users were able to access the building via a ramp at the front of the building.

Staff had access to a telephone translation service and interpreters should they be needed. Fact sheets explaining the role of the GP and the remit of the health service were available in a range of languages. The practice website enabled patients to obtain the information they required in a language of their choice. Staff were able to supply their practice booklet, and other practice information, in large print for the visually impaired. The practice had liaised with their website provider to ensure that the information on their website was available in a format suitable for the needs of patients with a visual impairment. Systems were in place which ensured that children with disabilities registering with the practice were offered an initial GP appointment, and that an alert was added to the parents' and child's clinical records to highlight their special needs.

Access to the service

The practice's core opening hours were Monday to Friday between 8am and 6pm. In addition, early morning and late evening extended hours appointments were also provided from: 6:30pm to 7:30pm on a Monday and Thursday evenings; 7am on a Tuesday morning; 7:30am on Wednesday, Thursday and Friday mornings. Early and late nurse appointments were also offered to accommodate working women. GP appointment times were as follows:

Monday: 8am to 7:20pm.

Tuesday: 7:10am to 5:20pm.

Wednesday: 7:30am to 4pm.

Thursday: 7:30am to 7:20pm.

Friday: 7:30am to 4:40pm.

The practice operated a mixed appointment system and some of their appointments, for non-urgent matters, could be booked up to one month in advance. Emergency appointments were available each day. We were told these could be used for patients presenting with an urgent same-day care need, as well as for vulnerable adults and children who were ill. Telephone consultations were also available, and these could also be booked four weeks in advance. Appointments could be booked online by patients who had registered for that service.

The patients we spoke with told us they were satisfied with the appointment system and they said it worked well for them. However, the results from the NHS GP Patient Survey of the practice, published in July 2015, showed that patient satisfaction with access to the practice and appointments was variable, when compared to the local CCG and the national averages. The practice had performed well in relation to appointment waiting times, and satisfaction with the practice's opening hours was broadly in line with

local CCG and national averages. However, patients were less satisfied with telephone access to the practice and their experience of making an appointment. Of the patients who responded to the survey:

- 73% were satisfied with the practice's opening hours, compared to the local CCG average of 79% and the national average of 75%.
- 52% said they could get through easily to the surgery by telephone, compared to the local CCG average of 81% and the national average of 73%.
- 40% described their experience of making an appointment as good, compared to the local CCG average of 78% and the national average of 73%.

In addition to the above, when we looked at the 'IwantGreatCare' website, of the 29 patients who responded, nine had raised concerns about access to appointments between January and December 2015.

The practice had been very responsive to patient feedback about their appointment system. We found staff had taken steps to improve access to the practice and the appointment system. The practice had commissioned the Primary Care Foundation (PCF) to carry out a review of how staff managed access and urgent care at the practice. We were told careful consideration had been given to the review findings and how these could be used to improve the service. Following the review, early and late appointment times had been introduced, to help improve access for working patients. Access to nurses had also been improved by increasing the number of consultation hours available. This had enabled the nursing team to increase the number of healthcare reviews they carried out. Staff told us they continued to monitor appointment availability closely and were constantly reviewing and 'tweaking' the practice's appointment system, in order to meet patients' needs.

We also found that, in light of the PCF review, and in response to a request from the local CCG, the practice had changed how they carried out home visits. We were told requests for home visits were now screened by a clinician within 30 minutes of being received and that they rang the patient back, within 90 minutes, to discuss their needs. All home visits were carried out by a designated GP each day. The managing partner told us these improvements helped the designated GP to carry out an early assessment of the needs of those patients requesting home visits. They said it also meant these patients could be seen more quickly and that there was more flexibility in arranging when a home visit took place.

Listening and learning from concerns and complaints

The practice had a system in place for managing complaints. This included having a designated person who was responsible for handling any complaints received by the practice and a complaints policy which provided staff with guidance about how to handle complaints. The complaints policy could be accessed via the practice's website and information about how to complain was available in the patient waiting areas. The policy advised patients how to escalate their complaint externally if they were dissatisfied with how the practice had responded. The practice had received five complaints about clinical matters during the previous 12 months. Information provided to us indicated these had been investigated and responded to appropriately. The managing partner told us any complaints received by the practice were discussed at the weekly clinical meetings and quarterly improvement meetings, so that opportunities for learning could be identified.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The GP partners and the managing partner were very committed to delivering high quality care and promoting good outcomes for patients, and they had a clear vision about how to do this. The strategy and supporting objectives were stretching and challenging, whilst remaining achieveable. The GP partners and their management team had prepared a statement of purpose which set out the aims and objectives of the practice. They had also prepared a clear and comprehensive 'Quality Improvement Strategy' (QIS) outlining how they intended to improve the quality of the services they provided to patients during 2015/16. The strategy identified the clinical leads for key areas of the service and the current improvement projects they were responsible for managing during this period. For example, projects to be overseen by the cancer and palliative care leads included: increasing bowel screening uptake rates; carrying out an audit of patients' preferred place of death; increasing the numbers of patients on the palliative care register, and carrying out significant event reviews for all patients newly diagnosed as having cancer. The implementation of the practice's QIS was underpinned by quarterly improvement meetings. We looked at a sample of the minutes of recent meetings and saw these involved a range of practice staff and covered areas and issues outlined in the QIS, such as safeguarding and the care of vulnerable patients.

The practice website included a 'Patients' Charter' which clearly set out what patients could expect from the practice. The GP partners and practice management team were able to clearly describe the arrangements they had put in place to meet the needs of their patient population groups.

Governance arrangements

We saw evidence of highly effective governance arrangements. The practice had comprehensive policies and procedures governing their activities and there were very good systems in place to monitor and improve quality and identify areas of risk. Clinical leads had been identified for key areas, and this helped to ensure staff were kept up-to-date with changes to best practice guidelines, and changes to the Quality and Outcomes Framework. Regular clinical, practice, multi-disciplinary and quality improvement meetings took place. These promoted good staff communication and helped to ensure patients received effective and safe clinical care. Arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice. The practice proactively sought feedback from patients and had an active patient participation group (PPG). There were good arrangements for making sure the premises and equipment were maintained in a safe condition. There was a clear staffing structure and staff had a very good understanding of their own roles and responsibilities. A range of audits had been carried out to help improve patient outcomes and the quality of the care and treatment they received. The audits we looked at were on key clinical topics and showed evidence of lessons learned.

Leadership, openness and transparency

The leadership and culture at the practice were used to drive and improve the delivery of high-quality person-centred care. The GP partners and managing partner had the experience, capacity and capabilities needed to run the practice and ensure high quality care. Staff had created a culture which encouraged and sustained learning at all levels in the practice. Through their partnership working with other agencies, they had promoted quality and continuing improvement. The leadership at the practice prioritised high-quality, compassionate and safe care. An example of this was the time that had been allocated to a member of staff to act as the patient liaison adviser. The GP partners and managing partner encouraged a culture of openness and honesty, and this could be seen in how they encouraged staff to raise concerns. It was also evident in the way in which they identified and reported significant events. There was a clear leadership structure in place, and a culture and ethos which promoted high levels of staff satisfaction. Staff said they felt respected, valued and supported, and also told us they were very proud to work for the practice.

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

The practice encouraged and valued feedback from patients. There was an active and longstanding practice participation group (PPG) which met twice a year. The practice also had a virtual PPG whose members they contacted via email. The practice promoted the work of the PPG on their website, and also in a display in the main

Are services well-led?

Outstanding ☆

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

patient waiting room. We saw evidence that members of the PPG had contributed to the design of the practice's most recent patient survey, and that the results had been shared with them. The managing partner had devised an action plan to address the concerns identified in the survey. This plan included, for example, changing the way staff carried out home visits, increasing the number of GP appointments available and re-organising the delivery of services to meet the needs of patients with long-term conditions. We spoke with five members of the PPG who told us their involvement was welcomed and that they were encouraged to share their views and express their opinions.

Effective processes were in place to obtain feedback from staff via regular team meetings at all levels of the organisation and through the staff appraisal process.

Innovation

The leadership at the practice actively encouraged and supported continuous improvement at all levels within the practice, and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. The practice team was very forward thinking and demonstrated their commitment to developing innovative, patient focussed services through their involvement in, and support of, the 'Case Manager' and 'Care Navigator' initiatives. Staff had also achieved the Royal College of General Practitioners Practice Accreditation Award in 2013 which runs until 2016. In order to achieve this accreditation, a practice has to demonstrate a good standard of organisational practice, shared learning and quality improvement.