Dr Watson & Partners

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?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
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 Dr Watson & Partners on 24 September 2015. Overall the practice is rated as outstanding.

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.

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

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles.
- There were systems in place to reduce risks to patient safety, for example infection prevention and control procedures and health and safety assessments.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents, near misses and any identified safeguarding issues.
- Information about services and how to complain was available and easy to understand.
- The practice sought patient views on how improvements could be made to the service, through the use of patient surveys family and friends test and via the practice's patient participation group (PPG).
- Urgent appointments were available for patients the same day.
- Patients said they were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- 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.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as priority. A business plan was in place and was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- We saw that the practice was responsive to the needs of the local population. For example, the practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of the out of hours and secondary acute service and very positive patient survey results. We saw that in response to patients' feedback they had looked at innovative ways to improve access with a '24 hour interactive telephone system' where patients could book an appointment with their chosen GPs (for appointments within surgery hours) at any time over a twenty four hour period seven days a week. Fifty percent of the available appointments for the practice were available in this way.
- The practice had a very good skill mix which included advanced nurse practioners (ANP) who provided daily visits and support to a local nursing care home for those with a high need for medical care. The impact was to reduce unplanned hospital admissions and allowed for more effective use of GP hours.
- The practice provided comprehensive screening and regular reviews for patients at risk of developing long term conditions. The practice supported individuals with a named nurse and regular telephone consultancy to aid self-management of their condition. Long term conditions were regularly monitored and recalls made. Patients with diabetes had access to a consultant diabetologist at the practice.
- The practice has been innovative in its efforts to meet the needs of more patients. It employs ANPs and Physician Assistants and this enables the practice to offer an appointment system that is flexible to the health needs of patients. There is also an effective mentorship programme that supports these additional roles within the practice.
- The practice provided a weekly link for patients with mental health needs to access 'Right Steps' support sessions. This is part of improving access to psychological therapies (IAPT) scheme. Patients can self-refer into the service in order to receive support promptly.
- The practice monitored accident and emergency (A&E) attendance daily and directly contacted patients who had attended A&E to review where access to their service could improve.
- The practice contacted 'carers' to offer individual support and direct them to additional services.
- The practice held a weekly dedicated Dementia 'memory' clinic. All staff and the PPG had received dementia training.
- The practice had a health trainer to support weight management, alcohol reduction and smoking cessation and could demonstrate this had a positive impact for patients using this service.
- The practice offered enhanced services including a prostate clinic and bladder scanning service, joint service and in-house physiotherapy, audiology and ultrasound services.
- The practice looked at organisational values and future visions in monthly staff meetings and organised team 'away days' to promote ideas and team development.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated good for providing caring services. Care planning templates were available for staff to use during consultation. Information for patients about services was available and easy to understand. Patients we spoke with during our inspection said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. We saw staff treated patients with kindness, respect and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent

Summary of findings

appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff and patients were part of the decision making process and encouraged to develop ideas and innovative methods of practice and service delivery. The practice continually gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the care of older people. The practice offered proactive, personalised care to meet the needs of older people in its population. Longer appointments, home visits and rapid access were available for those patients with enhanced needs. The practice worked closely with other health and social care professionals, such as the district nursing team and community matron, to ensure housebound patients received the care they needed.

The practice had provided an additional service to a local nursing home with advanced nurse practioners visiting daily with pharmacist support. This had a positive effect of reducing hospital admissions and better patient care for older people with long term conditions and palliative care needs.

People with long term conditions

Outstanding ☆

The practice is rated outstanding for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.

All patients had a named GP and nurse and a structured regular review of their care to check their health and medication needs were being met. For those people with the most complex needs, the named clinician worked with relevant health and care professionals to deliver a multidisciplinary package of care. The patients were encouraged to self-manage their condition and were offered regular appointments or telephone consultancy to manage their condition. Patients told us how well this worked for them and gave them more confidence to manage their own condition.

Regular clinics were held for diabetes and patients had access to a consultant diabetologist at the practice.

Families, children and young people

Good ●

The practice is rated good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of accident and emergency (A&E) attendances.

Appointments were available outside of school hours and the premises were suitable for children and babies. Baby clinics and

anti-natal clinics were held weekly. Staff told us all young children were prioritised and the under-fives were seen on the same day as requested. Emergency appointments were held back each day for children less than 11 years, with more made available as required.

Patients we spoke with during our inspection told us children and young people were treated in an age-appropriate way and were recognised as individuals. The practice provided sexual health support and contraception, maternity services and childhood immunisations. Data showed immunisation uptake rates were comparable for the locality.

Working age people (including those recently retired and students)

Good 

The practice is rated good for the care of working age people (including those recently retired and students). The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible. For example, the practice had extended hours on Thursday evenings from 6.30pm to 8.15pm. The practice also offered online services, telephone triage/advice and a full range of health promotion and screening that reflected the needs of this age group.

Patients had access to a 24 hour automated telephone system to make appointments with a GP of their choices and to arrange prescriptions.

People whose circumstances may make them vulnerable

Outstanding 

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those who had a learning disability. Longer appointments were available for patients as needed. Annual health checks were offered for those who had a learning disability and data showed 100% of patients had received one in the last twelve months.

Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice worked with multidisciplinary teams in the case management of this population group. It provided information on how to access various support groups and voluntary organisations.

Summary of findings

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).

All patients with mental health needs had a named GP. Annual health checks were offered for these patients and data showed 94% had received one in the last twelve months which was 8% above the national average.

The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example the local mental health team. It provided information on how to access various support groups and voluntary organisations, such as IACT and MIND. Staff had received training on how to care for people with mental health needs. A week counselling service was available at the practice and patients could self-refer.

The practice actively screened patients for dementia and maintained a register of those diagnosed. It carried out advance care planning for these patients. The practice also held a weekly memory clinic and a health practioner was available at the surgery to assess individuals and refer them to the clinic. This enabled a 'fast track' to the clinic and supported patients with dementia promptly.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 306 survey forms distributed and 121 forms were returned. This is a response rate of 39.5%Dr Watson & Partners performance was consistently above that of other practices located within Wakefield Clinical Commissioning Group (CCG) and nationally:

- 89.3 % Describe their overall experience of this surgery as good (85.2 CCG)
- 92.3% Say the last GP they saw or spoke to was good at giving them enough time (87.9 CCG) average
- 97% describe their experience of making an appointment as good (CCG 70%)
- 98.7 had confidence and trust in the last GP they saw or spoke to (CCG 96%)
- 100% had confidence and trust in the last nurse they saw or spoke to (CCG 79%)

We saw that the NHS 'Family and friends' surveys were positive with 100% stating that they would recommend this practice.

As part of the inspection process we asked for CQC comment cards to be completed by patients. We received 51 comment cards which were unanimous in their response regarding the positive standard of care received. During the inspection we spoke with nine patients. Patients were clear that they received an excellent service from the practice and that they were treated with dignity and respect and included in decision making about their care. All said that they would recommend this practice to others.

Dr Watson & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, SPA practice nurse and a SPA practice manager.

Background to Dr Watson & Partners

Dr Watson and partners is located in the Carelton Glen area of Pontefract. They have 13171 registered patients. They have a higher than national average population of patients aged over 65.

The practice provides Primary Medical Services PMS under a contract with NHS England. The practice is also contracted to provide a number of enhanced services, which aim to provide patients with greater access to care and treatment on site. They offer enhanced services in, extended hours, childhood vaccinations and minor surgery.

This is a training practice and hosts a range of clinical and non-clinical staff. There are eight GP partners (four female, four male), one salaried GP a trainee Registrar, four advanced nurse practitioners, four practice nurses, two healthcare assistants and a phlebotomist. There were also two new staff starting work at the practice in the role of Physician's Assistants. These are supported by a practice manager, and an experienced team of reception/ administration staff.

The practice is open between 8am to 6:30pm Monday to Friday with extended hours, early morning openings every weekday morning and Thursday evenings from 6.30 to 8pm. When the practice is closed, out-of-hours services are provided.

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. 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.

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

How we carried out this inspection

Before visiting the practice we reviewed information we hold about the practice and asked other organisations and key stakeholders, such as NHS England and Wakefield Clinical Commissioning Group (CCG), to share what they knew about the practice. We reviewed policies, procedures and other relevant information the practice manager provided before the inspection day. We also reviewed the latest data from the Quality and Outcomes Framework (QOF) and national GP patient survey.

Detailed findings

We carried out an announced inspection on the 24 September 2015. During our visit we spoke with five GPs, two advanced practice nurses, a health care assistant, the practice manager and six reception/ secretarial staff. We also spoke with nine patients and representatives from the patient participation group PPG. We reviewed 51 CQC comment cards where a patient had shared their views and experiences of the practice.

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)

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto the system and automatically treated as a significant event. The practice carried out an analysis of the significant events.

Safety was monitored using information from a range of sources, including National Patient Safety Alerts (NPSA) and National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an acute medication had not been reviewed with a patient for several years and had not been picked up within the system. After investigation by the practice it was agreed that any repeat acute medicines must be reviewed via consultation with a clinician. The prescribing policy was reviewed and an explanation and apology given to the patient.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. 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 safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. A dedicated infection control lead was in place who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). 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. Prescription pads were securely stored and there were systems in place to monitor their use. However we did note that the GP bags contained inconsistent medication and were not properly audited. The practice manager confirmed this would be addressed with immediate effect.
- Recruitment checks were carried out and the three files we sampled showed appropriate checks had been undertaken prior to employment. For example, proof of

identification, references, qualifications, registration with the relevant professional body and the appropriate checks through the Disclosure and Barring Service (DBS).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure 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 received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. There were systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The guidelines were followed through risk assessments, audits and random sample checks of patient records.

From reviewing medical records, care plans and from discussions with clinicians, the practice demonstrated how NICE guidance for diabetes, dementia and chronic obstructive pulmonary disease (COPD) were followed. Staff described how they carried out comprehensive assessments to identify holistic needs of patients. We were shown the person-centred, joint care planning template the practice used for diabetes patients. There was evidence of individualised goals, patient engagement and referrals onto other services where required. Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes had regular health checks and were referred to other services when required. Ninety eight percent of patients with diabetes, on the diabetes register, had an influenza immunisation and risk classification. This was 5% above the national average.

The practice had identified a GP and nurse lead in specialist clinical areas such as end of life care, diabetes, heart disease and asthma. The practice provided a high level of diabetes service including Insulin and GLP-1 initiation in house. Specialist joint Diabetes clinics are held at the Surgery with the Diabetologist every 8 weeks when patient and case note reviews are done. Feedback from patients confirmed they felt the diabetes care provided was of a high standard.

We saw that clinicians followed up patients that had not attended hospital appointments, as identified from hospital letters, by calling patients personally or asking administrative staff to book the patients an appointment. The practice had a similar process in place to follow up patients on the unplanned admissions register that were discharged from hospital.

The practice was signed up to the national avoiding unplanned admissions enhanced service and also a locally agreed enhanced service which focussed specifically on the over 65s. The practice used computerised tools to identify patients who were at high risk of admission to hospital and automatically ensured housebound patients were on this register, so that this specific group of vulnerable patients could have their needs met. Patients on this register had annual or three monthly reviews of their collaborative care plans and a named GP acted as a co-ordinator for their care. We saw that after these patients were discharged from hospital they were followed up individually by the practice to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a process intended to improve the quality of general practice and reward good practice. Information collected for the QOF and performance against national screening programmes was used to monitor outcomes for patients. Data from 2013/14 showed:

- The practice had achieved 95.3% of the total number of points available and aligned with QOF (or other national) clinical targets.
- The percentage of patients with hypertension having regular blood pressure tests was higher than the local CCG and national average.
- Performance for mental health related indicators was higher than the local CCG and national average.
- The dementia diagnosis rate was higher than the local CCG and national average.

The practice kept a number of other registers to identify other vulnerable groups, for example carers, those with learning disability and mental health conditions.

The practice was registered as part of the Safer Places Scheme (local council voluntary scheme) that aims to assist vulnerable people with learning disabilities, autism

and dementia to feel safer when travelling independently. Staff were able to give examples of how this initiative had worked and how they had provided safety to vulnerable members of the public.

Patients who had a long term condition were reviewed on a three monthly or annual basis, dependent on individual need. The practice wrote and telephoned patients to remind them of their appointment. These patients were on a recall system which the practice audited on a monthly basis to ensure patients were followed up as necessary.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included coding and data input, scheduling and recalling clinical reviews, managing repeat prescriptions and monitoring accident and emergency (A&E) attendances.

Robust recall systems were in place for long-term conditions registers, with administrative staff sending out reminders to patients for annual reviews. When reviewing repeat prescription requests, administrative staff checked if patients were due an annual review and prompted patients via a reminder on the prescription script.

We also saw that within the records the practice had audited how they managed child protection information. The outcomes from the audits found that information was appropriately recorded but improvements to the coding needed to be made. This had now been put into place.

We were told that other audits were linked to medicines management information. The practice took part in the CCG prescribing incentive scheme audits, for example we saw an audit relating to antibiotic prescribing medicines. Clinical audits were carried out and all relevant staff were involved to improve care, treatment and patient outcomes. The practice could evidence quality improvement through completed clinical audits, for example, vitamin B, diclofenac and steroids prescribing audits. We also saw that the practice completed audits of contraceptive implants. All patients identified had been individually contacted and their medicine reviewed in line with best practice guidance.

The practice made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice made use of the gold standards framework for end of life care. It had a palliative care register and had weekly multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example frail elderly and those with long term and / or experiencing poor mental health. Structured annual reviews were also undertaken for people with long term conditions, for example diabetes, chronic obstructive pulmonary disease (COPD) and heart failure.

Out-of-hours reports information and hospital letters were all input onto an electronic document system and were shared out between clinicians and dealt with daily. Any information requiring actions was allocated back to the administration team where appropriate. Any A&E attendances raising concerns about vulnerable children were flagged to the lead GP for safeguarding children. Safeguarding Lead GPs attend the regular meetings with the Health Visitors to discuss any safeguarding issues affecting patients in the practice.

The practice had a strong working relationship with the community teams including the district nurses, health visitors, midwives, and community psychiatric nurses. Patients had access to a mental health gateway worker and also a range of counselling services. The practice had an in house counselling service 'Right Steps' service and a dedicated Memory clinic. One mental health worker told us she worked well with the practice's staff and complimented the GPs on their work with patients suffering from depression.

The practice's Advanced Nurse Practioners (ANP) had initiated a pilot project to offer a twice weekly service visiting a large nursing home, seeing acutely ill, chronic illness and end of life care patients. They also provided education to the care home staff. This project developed and has become part of the National Vanguard programme continuing over 5 days with 4 hour support each day. The ANP's audited the efficiency of the service and provided evidence of the reduction in admissions and A&E attendance.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence reviewed showed:

- An extensive skill mix among within the practice. GPs had additional diplomas in sexual and reproductive medicine, family planning, women's health, obstetrics, dementia, drug misuse and a GPSI (GP with a special interest) in dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation.
- Practice nurses had a diverse skill mix, with additional qualifications including diabetes, paediatric, learning disabilities, sexual health and implant training. Nurses, health care assistants and phlebotomists had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, asthma, COPD, diabetes and coronary heart disease.
- This is a training practice with a new GP Registrar every six months and Foundation Year 2 & 3 Doctors every 4 months. There are three student nurses per year. Trainees told us that they were welcomed and well supported by the practice.
- Managerial and administrative were up to date with training, which included safeguarding, fire procedures, and basic life support and information governance awareness. The practice had ensured that clinical and non-clinical staff had received in-house dementia training to improve awareness and most staff had received mental capacity act training. The practice had an induction programme for newly appointed staff which also covered those topics.
- There was a structured system for providing staff in all roles with annual appraisals of their work and for planning their training needs. Staff we spoke with told us they found their appraisal useful as it allowed them to reflect on their achievements and also parts of the job they found difficult. Individual training needs had been identified through the use of appraisals, meetings and reviews of practice development needs. Staff had access to, and made use of, e-learning training modules. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example in diabetes and COPD.
- Staff told us that regular team meetings and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team days were held every month.
- The numbers of ANP's had been increased at the practice, to provide a greater flexibility and choice of appointments to patients. The introduction of the physician's assistant (PA) role was to further enhance the flexibility of the service to patients. There were two PA's starting at the surgery this month and in order to offer patients greater access to appointments.
- Different skills were brought together and care was organized around the patient. This ensured better use of resources and a coordinated approach to the delivery of care. Examples included short term intervention such as requesting emergency care packages for patients recently discharged from hospital and on-going monitoring of their health needs in the community. Staff also discussed education and support for patients to self-manage their long term conditions for example, epilepsy, diabetes and asthma.
- The practice offered patients extended access to their services with early morning and evening appointments. GPs and ANP staff were on a weekend rota to provide support to provide a 7 day service in the local community. The practice was a member of CCG 'Network 4' which jointly offered weekend GP & ANP appointments at the local hospital 11-4pm. The hospital was next to the practice.

Coordinating patient care and information sharing

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

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on going care and treatment. This included when people moved between services, including when they were referred, or after they

were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

The practice worked closely with a local project supporting patients with enduring mental health problems. There was a weekly support group and mental health workers available at the practice. The practice also held a 'memory clinic' weekly, which provided support to patients with dementia and their carers.

We spoke with staff from a care home that the practice regularly supported. They were positive about the service they received and felt a strong partnership of care had evolved between the care home and the ANPs and GPs at the practice. They received daily support and the patients in the home had excellent support with their health, with both long term conditions and palliative care needs.

Alongside long term conditions clinics for asthma, diabetes, COPD and the 'healthy heart clinic', the practice offered further enhanced services. These included a prostate clinic, joint service, minor surgery, in-house physiotherapy, audiology, bladder scanning and ultrasound services. Patients told us how much they appreciated a local service which gave them prompter consultation and treatment.

Consent to care and treatment

The practice had systems in place to ensure all clinical staff had access to up-to-date guidelines from the National Institute for Health and Care Excellence (NICE), the local Clinical Commissioning Group (CCG) and local disease management pathways. Clinicians carried out assessments and treatments in line with these guidelines and pathways to support delivery of care to meet the needs of patients. For example, the local pathway for patients who have chronic obstructive pulmonary disease (a disease of the lungs). The practice monitored that these guidelines were followed through risk assessments, audits and patient reviews.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. We confirmed that clinicians had received training in the Mental Capacity Act 2005. Staff explained that patients' consent to care and treatment was always sought. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome. When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency. This is used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Health promotion and prevention

The practice had an informative website which could be set to display the information provided in 90 languages. The website provided information about a wide range of health and care topics arranged according the gender and age of patients to help people find the information they needed.

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

High importance was placed on educating patients to self-manage their conditions. We saw that patients with long term conditions were given a named nurse who regularly consulted with them regarding their condition and promoted self-management of their health. Patients were given the option of an appointment at the practice or a telephone consultation.

The practice had a nurse led support service for patients diagnosed with epilepsy. Patients were given an option of attending the practice or on going telephone support for advice and guidance. Staff will talk to patients about the various self-help courses and guide them with health information and support groups. Patients told us that they felt the choice given to them was excellent as they could easily fit their consultations into their working day.

For patients with diabetes clinical diabetologist led clinics were held at the practice to ensure that patients got a local and easily accessible service. There was additional support with diet and health and also an exercise coach available at the practice.

The practice provided a full family planning service including the fitting of contraceptive devices. Women taking the contraceptive pill were invited to attend the practice each year for to discuss long-term contraception.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice and their PPG group held 'open days' for their patients and local community. This was to provide an opportunity to further health promotion from the 'health and wellbeing team' and access to the self-management team to look at self-help courses for patients.

Childhood immunisation uptake rates for the vaccinations offered were comparable to both the local CCG and national averages. For example, uptake rates for children aged 24 months and under ranged from 87% to 98% and for five year olds they ranged from 97% to 100%. To provide flexibility for working parents, appointments for childhood immunisations were available throughout the week rather than on specific days.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80% which was 2.5% above national average. There was a policy to offer reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

The seasonal flu vaccination uptake rate for patients aged 65 and over was 74%. Uptake for those patients who were in a defined clinical risk group was 51%. These were also comparable to both the local CCG and national averages. Text reminders were sent to patients (with their consent) to book an appointment.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40 to 74. These included Well woman clinics. Where abnormalities or risk factors were identified, appropriate follow-up on the outcomes was undertaken.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. 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 and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 51 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with 9 members of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 91% said the GP was good at listening to them compared to the CCG average of 88% and national average of 88%.
- 92% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 99% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 96% and national average of 96%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.

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 decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 89%.
- 90% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. We also saw some information in Braille for patients with impeded sight and an audio loop was available for patients with a hearing impairment.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers. The practice individually contacted all carers to offer their services and signpost them to additional support, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and made a home visit. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Outstanding ☆

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, in reviewing accident and emergency admissions and overall service design improvements to reduce attendance and use of emergency services.

There was an active patient participation group (PPG) which met on a regular basis. The PPG carried out patient surveys and submitted proposals for improvements to the practice. The practice had acted on these, for example proposals for the installation of a hearing loop system and a reducing the height of the reception desk for wheelchairs. They had also worked with the practice in improving the availability and access to appointments.

We spoke with staff from a care home that the practice regularly supported. They were positive about the service they received and felt a strong partnership of care had evolved between the care home and the ANPs and GPs at the practice. They received daily support and the patients in the home had excellent support with their health, with both long term conditions and palliative care needs.

Patients were identified on the palliative care register which was reviewed at regular care meetings. The practice had an alert system to highlight these patients and those with a diagnosis of cancer so as to ensure they were offered same day access to the GP and / or nurse when they rang for an appointment. The practice staff told us improving patient access and communication with other agencies ensured continuity of care for patients and reduced hospital admissions.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by GPs, district nurses, social workers and health visitors.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example:

- The practice offered extended hours one evening a week until 8.15pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability.
- Home visits were available for patients who could not physically access the practice.
- Daily urgent access appointments were available for children and those with serious medical conditions.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities or long term conditions. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. Reception areas were lowered to make them accessible for wheelchair height. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The practice also provided a breast feeding room for nursing mothers. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Access to the service

The practice was open from 8 am to 6:30pm Monday to Friday and offered extended hours for pre-bookable appointments every weekday mornings from 7am to 7.45am plus a late evening surgery on a Thursday from 6.30pm to 8.00pm.

Appointments could be pre-booked via the practices 24 hour automated telephone service which gave access to 50% of the patient appointments. Appointments were available on line and by visiting the practice. Patients were also offered telephone consultations the same day by the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

ANP or on call GP. Patients told us that they could make an appointment in the early hours of the morning for later the same day and others that they could make appointments at the weekend for the following week.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking up to a day in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example one patient said that with the automated telephone system they had been able to book an appointment easily and that family members with children had on the same day got an emergency appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The complaints policy outlined the timescale the complaint should be acknowledged by and where to signpost the patient if they were unhappy with the outcome of their complaint.

Information how to make a complaint was available in the waiting room, the practice leaflet and on the practice website.

The practice kept complaints register for all written and verbal complaints. There had been seven complaints over the last 12 months. We found they had all been satisfactorily dealt with, identifying actions, the outcome and any learning. We saw that patients were responded to appropriately, with an explanation of the investigation and apology where appropriate. For instance one complaint was about access to phlebotomy appointments. This had been reviewed and changes made to the online system to ensure patients were able to access in future.

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 clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement and staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

The practice had a business plan in place and this was shared with staff and other stakeholders.

The practice held twice yearly 'away days' for the team to discuss the organisational vision and future team goals. Staff explained that they were encouraged to be part of 'ideas' and new development for the practice.

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
- There was a comprehensive understanding of the performance of the practice
- There was a programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions
- The practice carried out proactive succession planning
- A clear business plan was in place and shared with staff and other stakeholders

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff.

The partners encouraged a culture of openness and honesty. There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff told us that regular team meetings and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team days were held every month.

All staff were motivated and engaged with the ethos of the practice. Staff were empowered to be part of the continuous improvement processes of the practice and were involved in discussions about how to run the practice and how to develop the practice. The practice maximised the use of communication systems between staff to ensure patient's welfare for example there were daily referral meetings for all the GPs to review cases and provide peer support in addition to weekly clinical meetings and regular whole team meetings.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, they had recently recommended dementia training for staff which had now been implemented and the PPG had also participated in the learning event. Staff and patients were part of the decision making process and encouraged to develop ideas and innovative methods of practice and service delivery. The practice continually gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

The practice reception staff encouraged all patients attending to complete the new Friends and Family Test as a method of gaining patient feedback. The practice manager collected this information to identify any trends. We noted that surveys and PPG reports were displayed in the waiting area with a suggestion box for patients to use. The practice web site also held all the above information for patients to access and invited comments and suggestions via email.

Innovation

Are services well-led?

Good

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

There was a strong focus on continuous learning and improvement at all levels within the practice. Staff were positive about change and improving services for patients. The practice team was forward thinking and looked at ways to improve outcomes for patients in the area. For instance the practice had set up a pilot scheme with ANPs providing daily visits to patients in a local care home with support from a local pharmacist. The aim was to reduce hospital admissions and deal with long term conditions and palliative care. This has been successful and proven to reduce hospital admissions and free GP hours for other areas of patient care.

We also saw that the practice continually reviewed how it could improve access to appointments. For instance, they had introduced a 24 hour automated system and extended availability of hours with increased use of ANPs and PA to the practice team.