# Dr Kewal Krishan

## Quality Report

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

## Ratings

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

# 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 Dr Kewal Krishan on 9 February 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting, recording and addressing significant events.
- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice employed an advanced nurse practitioner who had extended training in sexual health and contraception to meet the needs of its higher than average younger population group.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by the management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. There was an effective system in place for reporting, recording and addressing significant events. Lessons were shared to make sure action was taken to improve safety in the practice. When there were unintended or unexpected safety incidents, patients received reasonable support, information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again. The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. Risks to patients were assessed and well managed.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework showed patient outcomes were at or above average when compared to the local and national average. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely to deliver current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However data from the national GP patient survey showed that patients rated the practice lower than others for some aspects of care related to planning and making decisions about their care and treatment. The response for nurses were similar to the national response in these areas. Information for patients about the services available was easy to understand and accessible. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

# Summary of findings

patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues 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. It had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. The practice had an active patient participation group and it proactively sought feedback from staff and patients, which it acted on. There was a strong focus on continuous learning and improvement at all levels.

# 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice offered home visits and the phlebotomists employed by the practice visited this group of patients to take blood when needed. Urgent appointments were available for older patients with enhanced needs.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Performance for diabetes assessment and care was similar to the national average (89.4% as compared to the national average of 89.2%). Performance for asthma assessment and care was higher than the national average (80.15% as compared to the national average of 75.35%). Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice maintained a register of patients with long-term conditions who required a home visit.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. The practice had a policy in place to ensure that any child under the age of three is seen immediately and any child under five is triaged and seen on the day. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. There were systems in place to identify and follow up children living in disadvantaged circumstances. One of the advanced nurse practitioners attended school meetings to provide clinical guidance for children and young people assessed as being at risk from harm. We saw positive examples of joint working with midwives. The practice employed an advanced nurse practitioner who had extended training in sexual health and contraception to meet the needs of its higher than average younger population group. The practice told us that they

were the highest user of long-acting reversible contraceptives (LARC, methods of birth control that provide effective contraception for an extended period without requiring the patient to take any action). The practice's uptake for the cervical screening programme was 83.1%, which was comparable to the national average of 81.83%.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Students in higher education were supported to register and de-register with the practice with ease. 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 age group. The practice appointment telephone line was open between 8.30am and 6.30pm and extended hours were offered three evenings per week.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability and carried out annual health checks for these patients. An easy read (pictorial) letter was sent to patients with a learning disability inviting them to attend the practice for their annual health check.

Staff had been trained to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The data showed that 93.75% of patients on the practice register who experienced poor mental health had a comprehensive agreed care plan in the preceding 12 months. This was comparable to the national average of 88.47%. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice regularly worked with multi-disciplinary teams in the case management of

# Summary of findings

people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 80%, which was comparable to the national average of 84.01%. Staff had a good understanding of how to support people with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was performing in line with local and national averages. A total of 378 surveys (5.8% of patient list) were sent out and 117 (38%) responses, which is equivalent to 1.8% of the patient list, were returned. Results indicated the practice performance was comparable to other practices in most aspects of care, which included for example:

- 86% patients said they could get through easily to the surgery by phone compared to the national average of 73%.
- 86% were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 84% described the overall experience of their GP surgery as fairly good or very good compared to the national average of 85%.
- 78% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 27 comment cards which were overall positive. Patients said they received good care from the practice, staff were very helpful and understanding, doctors listened to their problems, excellent care and advice was given to them by the doctors and staff were very professional.

We also spoke with four patients on the day of our inspection, and three members of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received. The practice monitored the results of the friends and family test monthly. The results for friends and family test for March 2015 to December 2015 showed that 46 patients were extremely likely to recommend the practice to friends and family if they needed similar care or treatment, 23 patients were likely to recommend the practice and two patients were unlikely to recommend the practice.

## Areas for improvement

**Action the service SHOULD take to improve**

- Ensure effective systems are in place to check and monitor that emergency equipment are appropriate for use to enable a safe and rapid response to the needs of patients in the event of an emergency.

# Dr Kewal Krishan

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP specialist advisor and a practice manager specialist advisor.

## Background to Dr Kewal Krishan

Dr Kewal Krishan is located in a residential area of Wolverhampton. It is situated in a purpose built single storey building. The practice is located in an area of high deprivation and falls within the 20% most deprived in England. The practice provides medical service to approximately 6,546 patients over two sites. The main practice is based at Mayfield Medical Practice at 272 Willenhall Road, Wolverhampton WV1 2GZ and the branch practice is located at The Surgery, Cromwell Road, Bushbury, Wolverhampton WV10 8UT. Both practices are purpose built and provide ground floor facilities with disabled access and ample parking for patients. For this inspection a visit was made to both the main and branch practice.

The practice team consists of one lead GP and two salaried GPs (two male and one female), who provide services which equate to 2.5 whole time equivalent GPs. The practice also use GP locums to support the clinicians and meet the needs of patients at the practice. The clinical practice team includes two advanced nurse practitioners who are both independent prescribers, two practice nurses, a health care assistant and two phlebotomists. The clinical staff are supported by a practice manager, an assistant practice manager/IT manager and seven receptionists and administration staff. In total there are 19 staff employed either full or part time hours.

The practice is open Monday and Thursday between 8am and 7pm, Tuesday and Friday from 8am to 6.30pm and Wednesday 8am to 8.30pm. Extended surgery hours are available three evenings per week. The practice does not provide an out-of-hours service to its patients but has alternative arrangements for patients to be seen when the practice is closed. Patients are directed to the out of hours service Primecare, the NHS 111 service and the local Walk-in Centres.

The practice has a contract to provide Primary Medical Services (PMS) for patients. This is a contract for the practice to deliver primary medical services to the local community. They provide Directed Enhanced Services, such as the childhood vaccination and immunisation scheme and minor surgery. The practice provides a number of clinics for example long-term condition management including asthma, diabetes and high blood pressure.

## Why we carried out this inspection

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

# Detailed findings

## How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 9 February 2016.

During our visit we:

- Spoke with a range of staff including GPs, practice nurses, and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

# Are services safe?

## Our findings

### Safe track record and learning

There was an open and transparent approach to learning and a system was in place for reporting and recording significant events. Staff told us they would inform the partners and or practice manager of any incidents to ensure appropriate action was taken. The practice carried out a thorough analysis of the significant events.

We reviewed significant events records and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety. The practice had recorded 14 significant events, both clinical and operational which had occurred between January 2015 and December 2015. For example, vaccines received at the practice were found incorrectly stored in a cupboard. The policy and process for immunisations were reviewed and nominated staff identified to log the receipt and appropriate storage of vaccines.

We found that significant event records were maintained and systems put in place prevented further occurrence. Minutes of meetings demonstrated that appropriate learning from events had been shared with staff and external stakeholders. We found that when there were unintended or unexpected safety incidents, patients received reasonable support, relevant information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

### Overview of safety systems and processes

The practice had policies in place for safeguarding children and vulnerable adults for staff to refer to. The Principal GP was the lead for safeguarding and one of the advanced nurse practitioners was the deputy in their absence. We found that staff could tell us who they would report safeguarding concerns to and this was the senior person on duty or their immediate manager. However not all staff were able to tell us who the lead clinician for safeguarding was. Staff we spoke with demonstrated that they understood their responsibilities and told us they had received training relevant to their role. Certificates of safeguard training at the appropriate level were seen for all staff. The practice had updated the records of vulnerable patients' to ensure safeguarding records were up to date. The practice shared examples of occasions when suspected safeguarding concerns were reported to the local authority safeguarding team. This involved where necessary providing reports and meetings with external agencies, such as social workers and the community mental health team. Our review of records showed appropriate follow-up action was taken where alleged abuse occurred to ensure vulnerable children and adults were safeguarded. For example children who had been identified as being at risk of harm had their records flagged on the practice computer system.

The practice had an infection control policy in place and supporting procedures were available for staff to refer to. There were cleaning schedules in place and cleaning records were kept. Treatment and consulting rooms in use had the necessary hand washing facilities and personal protective equipment which included disposable gloves and aprons. Hand gels for patients and staff were available. Clinical waste disposal contracts were in place. One of the nurse practitioners was the clinical lead for infection control. The practice was visibly clean and tidy. Comments we received from patients said that they found the practice to be clean and tidy.

A notice was displayed in the waiting room, advising patients they could access a chaperone, if required. All staff who acted as chaperones were trained for the role. Staff files showed that criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The 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. Records available showed that two medication audits had been carried out; one had a second cycle completed. Appropriate actions had been taken to review patients' medicines where necessary. Prescription pads and forms were securely stored and systems were in place to monitor their use.

Good

# Are services safe?

The practice nursing team consisted of two independent prescribers, both of whom worked as advanced nurse practitioners at the practice. Both practitioners received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow practice nurses to administer medicines in line with legislation. The practice had a system for the production of Patient Specific Directions to enable health care assistants to administer vaccinations after the completion of specific training and when a doctor or nurse were on the premises.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). The practice had plans in place to repeat DBS checks for existing staff annually.

**Monitoring risks to patients**

The practice management team were responsible for managing risks associated with providing services. We saw that where risks were identified action plans had been put in place to address these issues. A building maintenance policy and schedules for maintenance were identified by the practice. The practice had completed a risk assessment log where specific risks related to the practice were documented. We saw that each risk was rated and mitigating actions recorded to reduce and manage the risk.

Fire risk assessments of the building had been completed and staff told us that regular fire drills were carried out. Records we saw confirmed this and the last drill was carried out in December 2015. Electrical equipment had been checked to ensure the equipment was safe to use and clinical equipment was regularly maintained to ensure it was working properly. The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) and a legionella risk assessment had been carried out. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice had achieved scores of 100% and 98% for its ratings in a local CCG infection prevention and control audit.

There were emergency processes in place for identifying acutely ill children and young people. Staff told us that the number of children referred to the local paediatric assessment unit (PAU) was low. Some of the reasons for this were because the practice had a policy in place which ensured that children under the age of three were seen immediately and any child under five was triaged and seen on the day. Also one of the GPs had experience in the treatment and care of children. Staff we spoke with told us that children were always provided with an on the day appointment if required. Patients with a change in their condition were reviewed appropriately. Patients with an emergency or sudden deterioration in their condition were referred to a duty GP for quick assessment.

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 and staff with appropriate skills were on duty. The practice used GP locums to support the clinicians and meet the needs of patients at the practice. For example when clinicians were on leave. Systems were in place to ensure appropriate checks were carried out to confirm the suitability of potential staff to work with patients. The practice used an online system to carry out recruitment checks. This included confirming that the GP locums were registered with their professional body, had completed safeguarding training and had DBS checks completed.

**Arrangements to deal with emergencies and major incidents**

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff had received recent annual update training in basic life support. The practice had a defibrillator (this provides an electric shock to stabilise a life threatening heart rhythm) available on the premises and oxygen with adult and children's masks. Although systems were in place to ensure emergency equipment and medicines were regularly checked we saw that the pads needed to use the defibrillator safely were out of date. The practice manager told us that new pads had been ordered in December 2015. A receipt was available to confirm this and the practice was following up the reasons for the delay. 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. Staff

Good

# Are services safe?

were able to recall an incident and demonstrate that this was dealt with appropriately. A reflection on the action taken was written up and the outcome and learning shared with staff at a practice meeting.

The practice had a business continuity plan in place for responding to emergencies such as loss of premises, power failure or loss of access to medical records. The plan included emergency contact numbers for staff and mitigating actions to reduce and manage the identified risks. We saw records of a recent disruption at the practice which meant that the business plan was put into operation when the telephone lines were not operating. Telephones calls were diverted to the branch practice while the telephone lines were repaired. The practice reviewed the business plan to include details of mitigating action to be taken should both telephone lines be disrupted.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and systems were in place to keep all clinical staff up to date. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

**Management, monitoring and improving outcomes for people**

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and reviewed their performance against the national screening programmes to monitor outcomes for patients. The practice achieved 98.5% of the total number points available for 2014-2015 this was higher than the practice average across England of 94.2%. The practice clinical exception rate of 4.8% was lower than the CCG average of 7.5% and national average of 9.2%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Further practice QOF data from 2014-2015 showed:

- Performance for the assessment and care of patients diagnosed with diabetes was comparable to the national average (89.4% as compared to the national average of 89.2%).
- The percentage of patients with hypertension having regular blood pressure tests was comparable to the national average (85.05% as compared to the national average of 83.65%).
- Performance for mental health assessment and care was comparable to the national average (93.75% as compared to the national average of 88.47%).
- The dementia diagnosis rate was comparable to the national average (80% as compared to the national average of 84.01%).

Clinical audits were carried out to facilitate quality improvement and all relevant staff were involved in the practice aim to improve care and treatment and patient outcomes. We saw seven clinical audits carried out over the past 12 to 24 months. A second cycle had been completed for two of the audits to review whether improvements had been made. One of the audits first carried out in 2014 looked at whether antibiotic prescribing was in line with national guidelines and practice requirements. The practice repeated the audit in 2015. The outcome showed that on both occasions most antibiotic prescriptions were appropriate (79% in 2014 and 82% in 2015) and it was noted that the indication for prescribing antibiotics needed to improve.

**Effective staffing**

The staff at the practice were experienced and showed they had the skills and knowledge to deliver effective care and treatment. All staff had annual appraisals that identified their learning needs from which personal development plans were identified. All staff had had an appraisal within the last 12 months. Our interviews with staff confirmed that the practice provided training opportunities. A GP was the lead for palliative care and another was a GP trainer. The practice employed two experienced nurse practitioners; both were independent prescribers. One of the nurse practitioners had extended training in sexual health and had extended training in related topics of contraception and some sexually transmitted diseases. The practice also employed two phlebotomists so that patients could have blood tests taken at the practice or in their home rather than travel.

Staff had been supported to develop in line with their personal development plans to enhance their skills. For example, the practice healthcare assistant administered flu vaccines under patient specific directions. All staff had received training and updates annually in health and safety, fire safety, data protection, safeguarding, information governance, chaperone training, and basic life support. Staff had access to and made use of training opportunities with their peer groups, in-house and external training.

Good

# Are services effective?

## (for example, treatment is effective)

The practice could demonstrate how they ensured clinical staff attended role-specific training and updating for relevant staff. There was a training schedule in place to demonstrate what training staff had received or were due to receive. Staff had access to and made use of e-learning training modules and in-house training. The learning needs of staff were identified through a system of meetings and reviews of practice development needs. This included ongoing support during one-to-one meetings and appraisals. The practice was discussing with the practice nurses the support needed for revalidation (A process to be introduced in April 2016 requiring nurses and midwives to demonstrate that they practise safely).

**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 shared computer drive. This included risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. The practice shared relevant information with other services in a timely way, for example when referring patient's to secondary care such as a hospital or to the out of hours service.

The practice worked with other professionals on a regular basis to help coordinate patients care and treatment. Staff organised and attended multi-disciplinary team meetings to discuss patients approaching the end of their life with other professionals that were also involved in their care. This included palliative care nurses, community matron(s) and hospice nurses. The care needs of patients who were approaching the end of their life were reviewed with other professionals care meetings which occurred every three months.

**Consent to care and treatment**

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out 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 where appropriate, recorded the outcome of the assessment. We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, in do not attempt cardio-pulmonary resuscitation (DNACPR) records and before patients had any minor surgery procedure.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support. This included patients with conditions that may progress and worsen without the additional support to monitor and maintain their wellbeing. 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 and smoking. Patients were then signposted to the relevant service for example, smoking cessation clinics and dietary advice was available. We saw that information was displayed in the waiting area and also made available and accessible to patients on the practice website. Patients had access to appropriate health assessments and checks.

New patients were also offered a health assessment with the healthcare assistant. Any existing medicines taken were reviewed by a GP to ensure they were appropriate. Any concerns identified were forwarded to a GP. Patients with conditions that may progress and worsen received additional support to keep them healthier for longer. For example, 97.51% of patients diagnosed with diabetes had received the seasonal influenza immunisation. This was higher than the national average of 94.45%.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Data collected by NHS England for 2014 -2015 showed that the performance for all childhood immunisations was comparable to the local CCG average. For example, 95.9% of children aged two had received the measles, mumps and rubella (MMR) vaccine. This was slightly higher than the CCG average of 92.9%.

The uptake for cervical screening for women between the ages of 25 and 64 years for the 2014-2015 QOF year was 83.1% which was comparable to the national average of 81.83%. The practice was proactive in following these patients up by telephone and sent reminder letters. Public Health England national data showed that the practice was comparable with local and national averages for screening for cancers such as bowel and breast cancer.

Good

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. We saw that reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and patients were offered a private area where they could not be overheard to discuss their needs.

We spoke with four patients and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 27 completed cards which were positive about the caring and compassionate nature of staff. Patients commented that the service was excellent, they were treated with respect and dignity and that GPs and staff were knowledgeable and caring. All of the patients we spoke with told us they were treated with care dignity, respect and understanding. We also spoke with three members of the patient participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Their comments were in line with the comments made in the cards we received.

Results from the national GP patient survey published in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs, for example:

- 71% said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 73% said the GP gave them enough time (CCG average 83%, national average 87%).
- 87% said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 75% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 85%).

Further results however showed that the practice was similar to average scores for patients' satisfaction on consultations with a nurse and experience with a receptionist. For example:

- 92% said the nurse was good at listening to them compared to the CCG average of 90% and national average of 91%.
- 92% said the nurse gave them enough time (CCG average 91%, national average 92%).
- 91% said they had confidence and trust in the last nurse they saw (CCG average 96%, national average 97%).
- 90% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89%, national average 91%).
- 92% said they found the receptionists at the practice helpful (CCG average 85%, national average 87%).

**Care planning and involvement in decisions about care and treatment**

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

Results from the national GP patient survey showed patients responded less positively to questions about their involvement in planning and making decisions about their care and treatment. Results related to GPs were much lower than the local and national averages, for example:

- 70% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 67% said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%).

The response for nurses from patients to these questions, however were in line with the local and national averages, for example:

Good

# Are services caring?

- 90% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 90%.
- 84% said the last nurse they saw was good at involving them in decisions about their care (CCG average 83%, national average 85%).

**Patient and carer support to cope emotionally with care and treatment**

Patients and carers gave positive accounts of when they had received support to cope with their care and treatment. We heard positive experiences about the support and compassion they received. For example, a patient told us about the ongoing support and advice they received whilst receiving treatment for a serious medical condition.

Written information was provided to help carers and patients to access support services. Notices in the patient waiting room and information on the practice website told patients how to access a number of support groups and organisations. This included organisations for poor mental health, bereavement and advocacy services. Patients were made aware that their consent was required before a carer or relative could receive or discuss any issues related to their care with staff.

The practice's computer system alerted GPs if a patient was also a carer. 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, the GP contacted them. Patients we spoke with confirmed this. There were seven carers on the practice carers register. This represented 0.11% of the practice population. This was less than the expected 2% for the practice population size. The practice identified some of the reasons for this as being due to the relatively low number of elderly patients registered at the practice and the practice did not provide a service to any care homes.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. The lead GP told us that they attended clinical commissioning group (CCG) meetings and they were aware of the practice performance in benchmarking with local practices.

We spoke with three members of the patient participation group (PPG) about how the practice and the group worked together. (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). The three members told us that they were happy with services provided at the practice and they felt involved with planning services. Services were planned and delivered to take into account the needs of different patient groups, flexibility, choice and continuity of care. For example:

- Patients who were at the highest risk of an unplanned admission to hospital were supported by individual care plans. If they were admitted to hospital, a GP or nurse practitioner contacted them when they were discharged to reassess their care needs.
- The practice had employed an advanced nurse practitioner with extended training in sexual health to meet the needs of its higher than average younger population group.
- There were longer appointments available for patients with a learning disability, older people and patients with long-term conditions.
- Home visits were available for older patients and patients who would benefit from these, which included patients with long term conditions or receiving end of life care.
- Urgent access appointments were available for children and those with serious medical conditions.
- Telephone consultations were available every day after morning and evening clinics.
- Telephone access was available to support meeting the needs of patients who were hearing impaired.
- Extended opening hours were available one evening per week for people who worked.

**Access to the service**

The practice was open Monday and Thursday between 8am and 7pm, Tuesday and Friday from 8am to 6.30pm and Wednesday 8am to 8.30pm. Extended surgery hours were available three evenings per week. The practice did not provide an out-of-hours service to its patients but had alternative arrangements for patients to be seen when the practice was closed. Patients could make appointments with a GP or practice nurse online. Patients who required a home visit were asked to contact the practice before 10am. Patients were directed to the out of hours service Primecare, the NHS 111 service and the local Walk-in Centres. This information was available on the practice answerphone, patient leaflet and practice website.

Results from the national GP patient survey published in January 2016 showed that patient's satisfaction with how they could access care and treatment was higher than the local and national averages in most areas.

- 76% of patients were 'Very satisfied' or 'Fairly satisfied' with the practice's opening hours compared to the local CCG average of 76% and national average of 75%.
- 86% patients said they could get through easily to the surgery by phone compared to the local CCG average of 70% and national average of 73%.
- 86% patients said that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment compared to the local CCG average of 82% and national average of 85%.
- 50% patients said they always or almost always see or speak to the GP they prefer (CCG average 58%, England average 59%).

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

**Listening and learning from concerns and complaints**

The practice had an effective system in place for handling complaints and concerns. The practice complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system including a summary leaflet available in the reception area. The leaflet provided clear guidance for patients on how to escalate their concerns if they were not happy with the practice response. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

We saw records for eight complaints received over the past year and found that all had been responded to, satisfactorily handled and dealt with in a timely way. Records we examined showed that the practice responded formally to both verbal and written complaints. Lessons were learnt from concerns and complaints and action was taken to improve the quality of care. Records also showed that the practice engaged with external stakeholders where needed to resolve complaints.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff and patients felt that they were involved in the future plans for the practice, for example the practice sought the views of patients and input of the patient participation group (PPG) to review and improve waiting times and communication within the practice and on the practice website. PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. The practice plans for the future development of the practice included becoming a centre for excellence for the care and treatment of children, sexual health, diabetes and providing management training.

**Governance arrangements**

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

- We found that systems were supported by a strong management structure and clear leadership.
- Risk management systems, protocols had been developed and implemented to support continued improvements.
- A programme of clinical and internal audit had been implemented and was used to monitor quality and to make improvements.
- The GPs, nurses and other staff were all supported to address their professional development needs. Checks were made to ensure that clinical staff held current professional registration.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Health and safety risk assessments had been conducted to limit risks from premises and environmental factors.
- Equipment at the practice was checked for safety and accuracy.
- 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.

**Leadership and culture**

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

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents, sharing complaints received and significant reporting. When there were unexpected or unintended safety incidents the practice gave affected people reasonable support, relevant information and a verbal and written apology. Staff described the culture at the practice as open and transparent. There was a practice whistle blowing policy available to all staff to access on the practice's computer system. Whistle blowing occurs when an internal member of staff reveals concerns to the organisation or the public, and their employment rights are protected. Having a policy meant that staff were aware of how to do this, and how they would be protected.

Clinical staff met on a weekly basis to discuss clinical performance and changes to clinical guidelines, formal records were not always made for these meetings however staff commented on the value for sharing information in this informal and opportunistic way. Regular practice, clinical and team meetings involving all staff were held monthly, minutes were taken and staff felt confident to raise any issues and were encouraged to give suggestions on how services could be improved.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. There was an active PPG which met regularly and submitted proposals for improvements to the practice management team. The minutes of the PPG meetings carried out in 2015 showed that services at the practice had been discussed. We spoke with three members of the PPG they told us that they were encouraged to raise any concerns they had.

# Are services well-led?

Good

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

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. This included reviewing waiting times and access to the practice. Records showed that action taken by the practice included making more appointments available and improved access for telephone triage of urgent patients and patients who may just need advice rather than a physical appointment.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the management team. Staff told us they felt involved and engaged to improve how the practice was run.

**Continuous improvement**

The practice had completed reviews of significant events and other incidents. We saw records to confirm this. Minutes of meetings demonstrated that appropriate learning from events had been shared with staff and external stakeholders.

The practice employed an advanced nurse practitioner who had extended training in sexual health and contraception to meet the needs of its higher than average younger population group. The practice showed us evidence of the increased uptake of sexual health and contraception services at the practice over the year (2015).

The management team was aware that the number of patients registered at the practice had increased. To address this, plans were in place to appoint additional GPs. Aligned to this the practice had reviewed the skill mix of staff and had increased nursing and clinical support staff to ensure the needs of patients could be met in the long term. For example the hours provided by the advanced nurse practitioner who specialised in sexual health was increased to meet the increased patient demand. The practice also planned to work towards becoming a GP training practice. To support this, the practice had one GP trainer and another was keen to develop in this role.