City Health Practice Limited- Marfleet

Quality Report

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Date of inspection visit: 3 May 2017
Date of publication: 07/06/2017

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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Marfleet Lane Surgery on 3 May 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had systems in place to minimise risks to patient safety. However we found that procedures to ensure systems were in place to monitor and act on problems were not robust.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Most patients we spoke with said they had had some difficulty in making an appointment even for urgent issues but there was continuity of care. The practice were aware of this and had put measures in place to address it.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
  - The practice had a number of policies and procedures to govern activity, but some were overdue a review.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

Summary of findings

- Carry out clinical audits and re-audits to improve patient outcomes.
- Review and update a number of policies, procedures and guidance.
- Have systems in place to check that refrigerator temperatures are monitored daily and that any action is taken as necessary.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- There was limited evidence of clinical audit that demonstrated quality improvement but the practice had identified this as an action to be addressed.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was 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.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the practice had recently commenced a monthly 'drop in' service for elderly patients and those with social problems which was developed in partnership with the Citizens Advice Bureau. Other services such as a debt counselling agency and Age UK attended the practice monthly.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Some patients we spoke with said they found it difficult to make an appointment with a GP but when they did there was continuity of care. The practice had an action plan in place and had implemented new ways of working to address this.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings. However we found that a number of policies were overdue a review.
- Although risks to patients were assessed, the systems to address these risks were sometimes not implemented well enough to ensure patients were kept safe.
- The governance framework that supported the delivery of the strategy and good quality care was relatively new and not yet embedded into practice. Medicine management was not robust

as monitoring and recording of refrigerator temperatures was not consistent, we found gaps in the recording process of temperatures and omission of action following recording of temperatures which were out of the acceptable range for safe management of vaccines.

- Arrangements to monitor and improve quality and identify risk also required improvement as there was limited evidence of clinical audit. Staff told us that they had undertaken a fire drill within the last year, however there was no documented evidence to support this.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The management team encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- The practice had recently commenced a weekly 'drop in' service for elderly patients and those with social problems.This session had been developed in partnership with the Citizens Advice Bureau and provided a means to signpost patients to other services.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months was 87%, which was comparable to the local and national averages.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 79% which was comparable to the local and national averages.

Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people.

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 these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours.

Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice had implemented eConsult (an electronic consulting service) to support healthcare. This provided a facility whereby patients were able to consult online with their own GP with a response no later than the end of the next working day.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months, was 95% which was above local and national averages.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment. The practice had recognised that the number of identified dementia patients were low and had implemented ad-hoc screening.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with local and national averages. 291 survey forms were distributed and 107 were returned. This represented 3% of the practice's patient list.

- 84% of patients described the overall experience of this GP practice as good compared with the CCG average of 82% and the national average of 85%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.
- 70% of patients said they would recommend this GP practice 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 CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards which were all positive about the standard of care received, with one comment regarding long waiting times for routine appointments.

We received four completed patient questionnaires during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring, but three of the four stated that they had to wait too long for an appointment. The most recent friends and families test was that 93% of patients were likely or extremely likely to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Carry out clinical audits and re-audits to improve patient outcomes.
- Review and update a number of policies, procedures and guidance.
- Have systems in place to check that refrigerator temperatures are monitored daily and that any action is taken as necessary.

City Health Practice Limited- Marfleet

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to City Health Practice Limited- Marfleet

City Health Practice (CHP) Ltd Marfleet (also known as Marfleet Lane Surgery) is a GP practice situated in the middle of a large inner city housing estate in Hull. It has approximately 3388 patients mainly from a white British background. The practice is in an area measured as having high levels of deprivation and is scored as one on the indices of deprivation. Practices with high levels of deprivation typically have more need for health care services.

CHP Ltd is a new company incorporating Southcoates Medical Centre and Marfleet Lane Surgery. CHP Ltd has a Service Level Agreement with City Health Care Partnership CIC, a large local community partnership to provide assistance with corporate back office and organisational functions to support the new company.

It has been a transitional time as the staff are getting used to working as part of a larger team and the surgery has recently had a change of clinical system to bring them in line with the other surgeries within our care group.

The practice has one full time GP (male) and one regular locum GP (female) who works one day per week. The practice has a Practice Manager, Practice Nurse (female), Health Care Assistant (female) and six reception staff. The practice is currently advertising for a GP and a Nurse Practitioner.

City Health Practice Ltd Marfleet has a car park at the side of the building. Disabled parking is available. A disabled patient's toilet is provided and there is wheelchair access. There is also an induction loop for patients with hearing impairment. The surgery is served by several regular bus routes.

The practice is open between 8am and 8.20pm on Monday and 8am and 6.30pm Tuesday to Friday. Morning GP appointments range from 8am to 12.40pm. Afternoon GP appointments range from 14.20pm to 8.10pm. Extended hours appointments are offered on Mondays from 6.30pm to 8.10pm.

When the practice is closed patients are advised to contact the Out of Hours service (111) provided by City Health Care Partnership CIC.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Clinical Commissioning Group to share what they knew. We carried out an announced visit on 3 May 2017. During our visit we:

- Spoke with a range of staff including reception staff, GPs, the management team and nursing staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards and questionnaires where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, after an incident whereby a medicine was inappropriately prescribed the practice implemented a safeguard on the computer system to ensure this would not happen again.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. 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 in the organisation. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules in place.
- The lead nurse in the wider organisation was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that some action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines in the practice mainly minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). The exception to this was in the management of vaccines as refrigerator temperatures were not recorded appropriately or reacted to when found to be out of range. On identification of this the practice took immediate action, the vaccines were kept in cold storage under quarantine and the medicines management team of the provider were contacted for advice.

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads

were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We found that the recruitment policy instructed the practice to make appropriate recruitment checks prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. The practice had a low staff turnover, all staff working at the practice had been employed in excess of four years.

Monitoring risks to patients

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and we were told by staff that they carried out regular fire drills, however these were not documented. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice had an action plan with regards to staff shortages and were currently trying to recruit a GP and a Nurse Practitioner. They also intended to share staff from their sister practice if required.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had oxygen with adult and children's masks. A first aid kit and accident book were available. There was no defibrillator however the practice had risk assessed this and we were told that the area had two emergency responders nearby.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.5% of the total number of points available compared with the clinical commissioning group (CCG) average of 92% and national average of 95%. The clinical exception reporting rate was comparable to local and national figures at 12.9%. (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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was similar and in some cases above the CCG and national averages. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who had a record of being referred to a structured education programme within 9 months after entry on to the diabetes register was 100% and the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 87%.
- Performance for mental health related indicators was higher than the CCG and national averages. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of blood pressure in the preceding 12 months was 95% which was above local and national averages.

There was limited evidence of quality improvement including clinical audit. The practice had identified this and an increase in audit activity was on their action plan.

- Findings were used by the practice to improve services. For example, recent action taken as a result of identification of low prevalence of patients with dementia included the implementation of ad-hoc screening for patients who were deemed to be at risk of developing the disease.

Information about patients' outcomes was used to make improvements such as: retinal screening rates had improved following identification of a low up-take by patients at the practice by increasing patient awareness. The practice had also acknowledged that breast screening rates were lower than local and average rates and we saw evidence of posters on display to advertise this service to patients and raise awareness.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the

scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a quarterly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice had identified a need for advice for patients with social problems, for example regarding debt management and state benefits and had collaborated with the citizens advice bureau to provide weekly drop in sessions at the practice. Patients were able to self-refer to this service; it was well advertised and initially available to the older population but rolled out to all patients due to the success of the initial sessions. Patients were signposted to other services they may need such as Age UK and debt management services.

The practice's uptake for the cervical screening programme was 86%, which was above the CCG average of 81% and the national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable and in some cases above CCG and national averages. For example, the practice achieved 100% uptake rates for the vaccines given to under two year olds and 90% uptake rates for the vaccines given to five year olds.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Good

Are services effective?

(for example, treatment is effective)

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 16 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Staff told us that the practice was small and friendly and that they knew their patients and were better able to help them because of this. We were told of a staff member who had accompanied a vulnerable patient to an appointment in their own time.

We received CQC questionnaires from four patients and feedback from one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 89% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 93% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 82% of patients said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

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

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.

Good

Are services caring?

- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 35 patients as carers (just over 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. Carers received an annual health check, flu vaccination and were referred to the local carer's service if required.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered extended hours on a Monday evening until 8.20pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS, and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Patients with social problems were able to access a monthly drop-in clinic organised by the practice in collaboration with the Citizens Advice Bureau.
- The practice had considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Access to the service

The practice was open between 8am and 8.20pm on Mondays and 8am and 6.30pm Tuesdays to Fridays. Morning appointments with GPs ranged from 8am to 12.40pm and afternoon appointments were from 14.20pm to 6.10pm. Extended hours appointments were offered on Mondays from 6.30pm to 8.10pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable and in some cases lower than local and national averages.

- 75% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 64% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 78% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and the national average of 85%.
- 94% of patients said their last appointment was convenient compared with the CCG average of 92% and the national average of 92%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.
- 80% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

Patients told us on the day of the inspection that they were sometimes not able to get appointments when they needed them. The practice had identified that access was their main issue and had an action plan in place. This included;

- The implementation of same day appointment triage by the GP to assess correct need.
- The education of patients to be aware that other services may be more appropriate e.g. pharmacists.
- The introduction of an electronic consulting system whereby patients were able to consult by email with a response within 24 hours from the GP. This also facilitated signposting if another service was more appropriate.
- The collaboration of staff at the sister practice and across the wider organisation to provide support and cover.
- The ongoing recruitment of clinical staff.
- Changes to GP appointment times and accessibility, including extended hours and telephone appointments.

The practice had a system to assess:

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

The GP telephoned the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its 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 such as posters and patient leaflets.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, staff were given further training with regard to the importance of documentation of patient contacts in the patient's clinical record following a complaint about staff attitude.

Are services well-led?

Requires improvement

(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 clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

On the day of the inspection we found that there were weaknesses in governance systems such as ineffective monitoring of procedures. This included refrigerator temperature monitoring for storing vaccines. The practice immediately responded to the findings following the inspection. The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This overarching governance was provided by City Health Care Partnership CIC but was relatively new and not yet embedded. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- Policies were implemented and were available to all staff however we found that some policies were overdue a review with renewal dates of January 2017.
- The practice did not have a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, however we did see some failure in the system.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.

Leadership and culture

The practice told us they prioritised safe, high quality and compassionate care. Staff told us the GP's and management team were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The management team encouraged a culture of openness and honesty. From the sample of three documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the GP and management team in the practice. All staff were involved in discussions about how to run and develop the practice, and the management team encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

Are services well-led?

Requires improvement

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

- patients through the patient participation group (PPG) and through surveys and complaints received. For example, the practice had changed the telephone system and appointment times in response to patient feedback.
- the NHS Friends and Family test, complaints and compliments received
- staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We were told that a member of staff had identified the need for social prescribing amongst patients which had led to the implementation of the drop-in sessions by the citizens advice bureau. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

The practice was on a trajectory of change and improvement with the new governance structure. Action plans had been put in place. The new providers had changed the clinical system to become in line with the wider organisation, local practices and care providers. Under governance of City Health Care Partnership CIC they planned to share staff and expertise from other practices and develop new innovative ways of working on a larger scale.