

# Rydal Group Practice

## 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 Rydal Group Practice on 17 January 2017. Overall the practice is rated as good.

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

- Refresher training around safeguarding and infection prevention was overdue for some staff although we saw confirmation from a training provider showing specific dates when this training would be provided.
- Risks to patients were assessed and well managed with the exception of fire safety risks.
- All staff who acted as chaperones had undertaken DBS checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- 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 patients and meet their needs.
- 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 and complied with the requirements of the duty of candour.

# Summary of findings

The areas where the provider should make improvement are:

- Ensure that all staff follow through with planned training in safeguarding and infection prevention and control.
- Ensure that risk assessments are carried out for non-clinical staff to ascertain whether DBS checks should be undertaken.
- Ensure a fire risk assessment is carried out and recommended actions are followed up promptly.
- Review how carers are identified and recorded on the clinical system to ensure information, advice and support is made available to them.
- Ensure planned improvements of arrangements to support patients with hearing impairments are implemented.
- Consider putting arrangements in place to review how patient consent forms are used at the practice.

**Professor Steve Field CBE FRCP FFPH FRCGP**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

Good



- Training updates around safeguarding and infection control were overdue for some members of staff although specific dates had been booked when this training would be provided.
- Chaperones were available. This role was always filled by a member of the clinical team and all of these staff had undertaken DBS checks. The practice had not undertaken DBS checks for non-clinical staff but had carried out risk assessments for three of these staff and from these, had concluded that staff in these and similar roles did not require DBS checks. (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).
- Risks to patients were assessed and well managed with the exception of fire safety risks.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients 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.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with 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 other health care professionals to understand and meet the range and complexity of patients' needs.
- There was evidence of appraisals for all staff in the past 12 months.

# Summary of findings

## Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice above others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- 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.
- The practice employed a care co-ordinator who provided support to patients who had recently become carers and this member of staff had recently been given the responsibility of leading a review of the processes used to identify carers.

Good



## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example the practice had reviewed its appointment system, and having identified a demand for more telephone consultations and a GP led triage system, had taken action in response to this demand. Results from the national GP patient survey showed that patients rated the practice higher than others for access to appointments.
- 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 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.

Good



## Are services well-led?

The practice is rated as good 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.

Good



# Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance 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 with the exception of fire safety risks.
- 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 notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- 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

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Outcomes for conditions often associated with older people were comparable to local and national averages. For instance, 80% of patients with hypertension had well controlled blood pressure compared to the CCG average of 81% and the national average of 83%.

Good



### People with long term conditions

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.
- The practice performance rate for the Quality and Outcomes Framework (QOF) diabetes related indicators were comparable to the local and national average. For instance, 84% of patients with diabetes had well controlled blood sugar levels (CCG average of 68%, national average 78%).
- Patients who had recently been diagnosed with long term conditions but who were experiencing difficulties adjusting to their condition were offered support to develop strategies to help them feel more involved in decisions about their own care and treatment.
- 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.

Good



### Families, children and young people

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

Good



# Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 78% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

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

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.
- 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 provided GP led telephone triage and telephone consultations which benefitted patients who were unable to attend during normal working hours or who were unsure if their condition required a visit in person.
- Extended opening hours were available every morning and evening between Monday and Friday.
- Patients had access to appointments at a local hub service on weekday evenings between 6.30pm and 10pm, between 9am and 5pm on Saturdays and 9am and 1pm on Sundays.

Good



## People whose circumstances may make them vulnerable

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.
- The practice offered longer appointments for patients with a learning disability.

Good





# Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how 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 in normal working hours and out of hours.
- The practice care co-ordinator provided support to patients who had recently been bereaved or had become carers for the first time and helped these to navigate care pathways, access external support organisations and develop care plans.

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

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

- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had an agreed care plan documented in the record which was comparable to the national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and twenty one forms were distributed and 100 were returned. This represented 1% of the practice's patient list.

- 64% of patients found it easy to get through to this practice by phone compared to the local clinical commissioning group (CCG) average of 54%
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 65%, national average 76%).
- 88% of patients described the overall experience of this GP practice as good (CCG average 74%, national average 85%).

- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG average 68%, national average 80%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were all positive about the standard of care received. People said staff were helpful, kind and compassionate.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

# Rydal Group Practice

## 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 practice manager specialist adviser.

## Background to Rydal Group Practice

Rydal Group Practice provides GP primary care services to approximately 11,500 people living in Woodford Green, London Borough of Redbridge. The practice has a General Medical Services (GMS) contract for providing general practice services to the local population. General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Information published by Public Health England rates the level of deprivation within the practice population group as eight on a scale of one to ten. Level one represents the very highest levels of deprivation and level ten the lowest. This information also shows that Income Deprivation Affecting Older People (IDAOPI) is 14% which is lower than the CCG average of 21% and the national average of 16%. Income Deprivation Affecting Children (IDACI) is 13% (CCG average 19%, national average 20%).

There are currently five GP partners, two male and three female. The practice provides a total of 36 GP sessions per week.

The clinical team is completed by three practice nurses and a health care assistant all of whom work part time. The health care assistant is also trained as a phlebotomist

(Phlebotomists are specialist healthcare assistants who take blood samples from patients for testing in laboratories). There are also a practice manager, a deputy practice manager and thirteen administrative and reception staff.

The practice is registered with the Care Quality Commission to provide the regulated activities of maternity and midwifery services, diagnostic and screening procedures, family planning, treatment of disease, disorder or injury and surgical procedures.

The practice is located in a two storey building and patients are given the option of being seen on the ground floor. Consulting rooms are located on the ground floor.

The practice opening hours for the surgery are:

Monday 7:30am to 7:00pm

Tuesday 7:30am to 6:30pm

Wednesday 7:30am to 7:00pm

Thursday 7:30am to 7:00pm

Friday 8:00am to 6:30pm

Saturday Closed

Sunday Closed

The practice is also part of a federated group of local practices which provides pre-bookable appointments on weekday evenings between 6.30pm and 10pm, between 9am and 5pm on Saturdays and 9am and 1pm on Sundays. These are available at three different GP surgeries and include appointments with nurses as well as doctors.

The practice has opted not to provide out of hours services (OOH) to patients and these were provided on the practice's behalf by Partnership of East London

# Detailed findings

Co-operatives (PELC). The details of the how to access the OOH service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website.

Patients can book appointments in person, on-line or by telephone. Patients can access a range of appointments with the GPs and nurses. Face to face appointments are available on the day and are also bookable up to six weeks in advance. Telephone consultations are offered where advice and prescriptions, if appropriate, can be issued and a telephone triage system is in operation where a patient's condition is assessed and clinical advice given. Home visits are offered to patients whose condition means they cannot visit the practice.

The practice provides a wide range of services including clinics for diabetes, weight control, asthma, contraception and child health care and also provides a travel vaccination clinic. The practice also provides health promotion services including a flu vaccination programme and cervical screening.

## 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.

The practice had not previously been inspected.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 January 2017. During our visit we:

- Spoke with a range of staff including GPs, practice manager, practice nurse, health care associate and members of the administration and reception teams and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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.

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

The practice had recorded six significant events in the previous 12 months. We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we saw a record of an incident when a GP became aware a vulnerable patient was having difficulties managing their medicines and had not been taking the correct dose. The practice had contacted the patient's carer and with the carer's permission, the practice's internal care co-ordinator, to discuss ways of supporting the patient. We saw minutes which showed that the practice had arranged for a local pharmacy to supply medicines in blister packs to help the patient and their carer understand how to take the medicines properly. We looked at the patient's care plan and saw that this had been updated with details of the new protocol.

### Overview of safety systems and processes

We looked at the systems in place to keep patients safe and safeguarded from abuse:

- Arrangements were in place to safeguard children and vulnerable adults from abuse Policies were accessible to all staff. The policies clearly outlined who to contact for

further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Clinical staff had received recent training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding 3, nurses and the health care assistant were trained to level 2. All other staff were trained to level 1, although refresher training for non-clinical staff was now overdue. This had been booked for February 2017 but was postponed when the training organisation advised the practice that they were unable to fulfil the booking. The practice were able to show us confirmation that the training had been rebooked for April 2017. Staff we spoke with could demonstrate they understood their responsibilities, could describe signs of abuse and knew where to access the practice policy and how to report suspected abuse.

- A notice in the waiting room advised patients that chaperones were available if required. This role was always filled by a member of the clinical team and all of these staff had undertaken DBS checks. The practice had not undertaken DBS checks for non-clinical staff but had carried out risk assessments for three of these staff and from these, had concluded that staff in these and similar roles did not require DBS checks. (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).
- and this service was always provided by a member of the clinical team such as a nurse or health care assistant. All staff who acted as chaperones had undertaken DBS checks. The practice had not undertaken DBS checks for non-clinical staff. Risk assessments had been undertaken for three of these staff and from these, the practice had concluded that other staff who shared similar responsibilities did not require DBS checks. 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. The practice nurse was the infection control clinical lead who liaised with the

## Are services safe?

local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and although staff we spoke with demonstrated a sound understanding of infection risks and measures to prevent and control infection, there was no evidence that staff had received up to date training. However, we saw an invoice which confirmed that the practice had already booked and paid for staff to attend the appropriate training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice used a 'Handover Book' to communicate with the cleaning contractor and used this to pass messages about action points, performance and monitoring. These were reviewed and signed off monthly.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. However, we saw records for two patients who had been issued with repeat prescriptions for a medicine used in the treatment of insomnia and noted that these records did not include a date by which the patient needed to be seen by a GP to review their condition. We brought this to the attention of the practice and saw that these records were reviewed immediately and review dates set for both patients. The practice carried out regular medicines audits, with the support of the local CCG 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 in place to monitor their use. Patient Group Directions (PGDs) 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 against a patient specific prescription (PSDs) or direction from a prescriber. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PSDs are written instructions from a qualified

and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.

- We reviewed eight 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.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had appointed fire marshals, carried out regular fire drills and checked that fire alarms were in working order. Staff had received fire safety training but there was no evidence that a fire risk assessment had been carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly and the most recent checks had been undertaken within the past 12 months. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- 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 enough staff were on duty. The practice had a policy of rotating non-clinical staff to different duties over the course of the working day to ensure that each member of staff had a working knowledge of all administrative and reception functions. Staff we spoke with told us this meant they maintained competencies in a range of roles and enjoyed a more varied working day.

### Arrangements to deal with emergencies and major incidents

## Are services safe?

The practice had adequate arrangements in place 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.
- The practice had assessed risks associated with receptionists working alone at the surgery and had put a protocol in place which meant that there were always a minimum of two members of the reception team on duty and this included times when clinical sessions were delayed beyond normal closing time.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included details of a nominated buddy practice and emergency contact numbers for staff, utility companies and other significant contractors.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed 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 practice had systems in place 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.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice employed a qualified pharmacist as part of a three year pilot scheme to assess the impact of employing pharmacists in GP practices. The pharmacist took an active role in reviewing patient records to ensure new guidelines were being followed.

### 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% of the total number of points available which was higher than the CCG average of 92% and national average of 95%.

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

- Performance for diabetes related indicators were comparable to CCG and national averages. For instance, 84% of patients had well controlled blood sugar levels (CCG average of 68%, national average 78%). The exception reporting rate for this indicator was 17% (CCG average 10%, national average 13%). The percentage of patients on the diabetes register, whose last measured total cholesterol (measured within the preceding 12

months) was 5 mmol/l or less was 78% (CCG average 74%, national average 80%). The exception reporting rate for this indicator was 12% (CCG average 9%, national average 13%).

- Performance for mental health related indicators was comparable to the national average. For example, 89% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses (62 patients) had a comprehensive, agreed care plan documented in the record compared to the CCG average of 91% and national average of 89%. The exception reporting rate for this indicator was 2% (CCG average 6%, national average 13%).
- 80% of patients with hypertension had well controlled blood pressure compared to the CCG average of 81% and the national average of 83%. The exception reporting rate for this indicator was 2% (CCG average 3%, national average 4%).
- Outcomes for patients with asthma were comparable to CCG and national averages. For instance, 71% had had an asthma review in the preceding 12 months using a nationally recognised assessment tool compared to the CCG average of 76% and the national average of 76%. The exception reporting rate for this indicator was 2% (CCG average 11%, national average 12%).

There was evidence of quality improvement including clinical audit.

- There had been six clinical audits completed in the last two years, one of these was a completed audit where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Information about patients' outcomes was used to make improvements. For instance, the practice had undertaken an audit of the care provided to patients diagnosed with COPD. The first cycle had identified that of the 170 patients diagnosed with the condition, 93% had had a structured annual review of their condition in the previous 12 months and 88% had been instructed on inhaler technique. The practice had revised its processes for recalling patients and had invited patients diagnosed with COPD to appointments to have their condition reviewed. The practice repeated the audit one year later and had identified that the percentage of



# Are services effective?

## (for example, treatment is effective)

patients who had had a structured review had risen from 93% to 97%. The audit also showed that the percentage of patients who had been given instruction on inhaler technique had risen from 88% to 97%.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- 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 training to meet their learning needs and to cover the scope of their work. Staff we spoke with told us they had received ongoing support through one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff had received training that included 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. One

member of the administration team had been appointed to the part time of care co-ordinator at the practice. This person took a lead role in completing and reviewing care plans for patients who needed them.

- We were told that patients who could benefit from short periods of additional support were referred to the care co-ordinator. For example, we were given an example of a patient who had been diagnosed with a long term condition for the first time and who had experienced difficulties co-ordinating appointments and absorbing information during consultations. The care co-ordinator had spent time with this patient and had helped them develop management strategies such as using a notebook to record questions or concerns as they arose and bringing the notebook to appointments to ensure that these were addressed as well as then being able to make contemporaneous notes during consultations.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The pharmacist employed at the practice undertook regular prescribing reviews of patient records, including those of patients diagnosed with long term conditions. They used their specialist knowledge to provide advice to GPs and patients about side effects of medicines as well as the effects of different combinations of medicines, reviewed medicines of patients who had been discharged from hospital and helped patients to organise repeat prescribing through local community pharmacists. The pharmacist was being supported to qualify as an independent prescriber

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. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. We reviewed the document which patients were asked to sign when consenting to have contraceptive devices fitted and noted that this did not

# Are services effective?

## (for example, treatment is effective)

include details of the risks involved or a summary of any discussion which had taken place before consent was given. The practice provided us with a revised version of this form the day after our inspection and this included a section which showed that the risks associated with the procedure had been discussed and understood by the patient. The practice confirmed that this consent form would be used with immediate effect.

- 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.
- The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. 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. Patients were signposted to the relevant service.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of

78% and the national average of 81%. There was a policy to offer telephone 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 in place 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.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice's uptake rates for these screening programmes were comparable to CCG and national averages. For instance, 75% of eligible patients had been screened for breast cancer in the previous three years (CCG average 68%, national average 72%) whilst the uptake rate for bowel cancer screening was 58% which was higher than the CCG average of 48% and the same as the national average.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to under two year olds ranged from 80% to 87% and five year olds from 77% to 84%.

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

# 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.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice used a queue management system to maintain a reasonable distance between waiting patients and those already speaking with staff and this helped to maintain privacy in the reception area.
- Moveable screens were available for use in the event of medical emergencies.

All of the 37 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.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 87%.
- 91% of patients said the GP gave them enough time. (CCG average 82%, national average 87%).

- 89% of patients said they had confidence and trust in the last GP they saw. (CCG average 90%, national average 92%).
- 92% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 81%, national average 85%).
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG average 83%, national average 91%).
- 85% of patients said they found the receptionists at the practice helpful (CCG average 78%, 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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 to the CCG average of 81% and the national average of 86%.
- 83% 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%.
- 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 translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The practice care co-ordinator met with patients to develop care plans and provide information about

## Are services caring?

organisations who could provide additional support for patients who needed this. Patients who were unable to attend the practice could speak to the care co-ordinator by telephone.

### **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. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 98 patients as carers (less than 1% of the practice list). The practice care co-ordinator had recently been given a lead role in identifying carers and other patients who benefitted from additional support. As part of the strategy to identify carers, the care co-ordinator routinely contacted patients who had had an unplanned hospital admission and as well as updating patient records with details of the admission, used the opportunity to enquire whether the patient had caring responsibilities or were a carer themselves. The care co-ordinator provided patients, including carers, with advice and practical support. For instance, we were told this member of staff provided assistance navigating

secondary care pathways and signposting carers to support organisations. We saw evidence of a recent occasion when the care co-ordinator had supported a patient who had recently become a carer and helped them to devise strategies to manage their caring responsibilities.

The practice had recently undertaken an audit of the carers register to identify the last contact point with each carer and to ensure that all carers had had or been offered a recent health check. In addition to annual health checks, carers were offered annual flu vaccinations and longer appointment times when this was helpful. Written information was also available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered 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 and/or by giving them advice on how to find a support service. We saw details of a local community based bereavement support service where recently bereaved families met over morning coffee to receive and/or offer comfort and practical advice in the company of others in similar circumstances. We were told that staff would often attend patient's funerals in person.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. In 2012, the practice had undertaken a consultation exercise to identify where improvements could be made to the appointment system. This had identified a need for a GP led telephone triage service and an increased demand for more telephone appointments. The practice had responded to this by providing additional telephone sessions and developing a detailed protocol which ensured that patients received a call back within one hour. The practice had undertaken a second audit of this aspect of the service in 2015 and this had made a number of changes such as ensuring that patients who worked in public places were able to select a time for a call-back when privacy was more likely to be possible.

- The practice offered extended opening hours for working patients who could not attend during normal opening hours. This included appointments with the practice nurses and health care assistants.
- 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.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available and although the practice had ordered a hearing loop, this had not yet been delivered.
- Patients could access the appointment system and request repeat prescriptions online.
- The practice premises was listed at Grade II status by Historic England and this had inhibited efforts to improve access at the front entrance of the building. However, the practice had arranged step free access through a side entrance and reception staff told us that

when patients needed to use this entrance, they would meet them at the door and accompany them to the reception desk. The practice told us they had received approval to install an automated door at this entrance.

- The practice had produced a 17 page practice booklet which provided information including details of practice staff, clinics offered, the appointment system, childhood immunisations and out of hours arrangements. The booklet also provided information about a range of common ailments, suggestions for domestic medicine chests, repeat prescribing arrangements, local community services and details of the practice's patient charter.

### Access to the service

The practice opening hours for the surgery were:

Monday 7:30am to 7:00pm

Tuesday 7:30am to 6:30pm

Wednesday 7:30am to 7:00pm

Thursday 7:30am to 7:00pm

Friday 8:00am to 6:30pm

Saturday Closed

Sunday Closed

Extended hours appointments were offered between 7:30am and 8am and 6:30pm and 7pm every weekday except Friday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice was also part of a federated group of local practices which provided pre-bookable appointments on weekday evenings between 6.30pm and 10pm, between 9am and 5pm on Saturdays and 9am and 1pm on Sundays. These were available at three different GP surgeries and included appointments with nurses as well as doctors.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages although satisfaction around appointment convenience and availability was higher than average.

- 99% of patients said the last appointment they got was convenient compared to the CCG average of 86% and national average of 92%

# Are services responsive to people's needs?

(for example, to feedback?)

- 91% of patients said they had been able to make an appointment the last time they had tried (CCG average 65%, national average 75%).
- 77% of patients were satisfied with the practice's opening hours (CCG average 74%, national average 78%).
- 64% of patients said they could get through easily to the practice by phone (CCG average 54%, national average 73%).

People 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.

- 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. For instance, a poster which included an email address for the person responsible for managing complaints was displayed in the waiting area and a copy of the complaints procedure could be downloaded from the practice website.

We looked at five complaints received in the last 12 months and found these were handled in line with practice procedures. Lessons were learnt from individual concerns and complaints and action was taken to as a result to improve the quality of care.



# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had developed a practice charter which set out the values of the practice and the standards it aimed to maintain. For instance the patient charter stated that no patient should ever have to wait for more than 30 minutes in the waiting area without receiving an explanation for any delays. This charter was displayed in the waiting areas and the practice booklet and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions, although this did not include an assessment of the risks associated with fire.

### Leadership and culture

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

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when

things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place 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.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings.
- The reception and administration team held team briefings twice daily and used these to discuss workload, agree duty rosters and co-ordinate activities between staff who worked different shift patterns.
- 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.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. We were also told that staff enjoyed the social functions organised by the practice and that these were valuable bonding exercises which contributed to a cohesive working environment.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had helped the practice to review the amount of time provided for

# Are services well-led?

Good 

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

telephone appointments and had played a key role in developing the protocol to ensure that patients received call-backs at times of the day when it was suitable or safe to receive them.

- The PPG and practice collaborated to produce a quarterly newsletter which was distributed at the practice as well as being available online. This was used to provide information likely to be of interest to the practice population, including for instance, updates on changes at the practice, details of local community health initiatives or reminders about practice procedures such as how to get test results.
- The practice had gathered feedback from staff through annual staff away days and generally 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. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For instance, the practice had employed a pharmacist as part of a three year pilot scheme to assess whether employing pharmacists in GP practices improved outcomes for patients.