Barlow Medical Centre

Quality Report

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

Ratings

Overall rating for this service	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 Barlow Medical Centre on 10 July 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with urgent appointments available the same day. They told us they had to wait if they wanted an appointment with a specific GP.
- 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.

We saw areas of outstanding practice:

- A professor of Dementia Studies reviewed all dementia referrals and the practice had secured funding for dementia advisors at the practice. An audit of read coding had increased the number of patients on the dementia register from 50 to 74 without clinical intervention.

Summary of findings

- One of the GPs led research for the practice and had been involved in clinical trials since 1999. The GP was due to retire but was staying on in a research/clinical trial role until a GP was found with a particular interest in replacing them in this role.

However there were areas of practice where the provider could make improvements

Importantly the provider should:

- Update training records so all training is correctly recorded and updated training can be arranged appropriately.
- Check the understanding of chaperones so they stand in view of the patient during examinations.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed most patient outcomes were at or above average for the locality. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than 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 also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they could access urgent and routine appointments but had to wait if they wanted to see a particular GP. The practice had good facilities and was well equipped to treat patients and

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meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. 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 were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

One of the GPs led research for the practice and had been involved in clinical trials since 1999. This benefitted patients with long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. 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. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

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.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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.

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). Patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. A professor of Dementia Studies reviewed all dementia referrals and the practice had secured funding for dementia advisors at the practice. An audit of read coding had increased the number of patients on the dementia register from 50 to 74 without clinical intervention.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing in line or slightly below local and national averages.

- 72% find it easy to get through to this surgery by phone compared with a CCG average of 67% and a national average of 73%.
- 82% find the receptionists at this surgery helpful compared with a CCG average of 85% and a national average of 87%.
- 54% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 58% and a national average of 60%.
- 81% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 83% and a national average of 85%.
- 91% say the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 63% describe their experience of making an appointment as good compared with a CCG average of 69% and a national average of 73%.
- 53% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 62% and a national average of 65%.
- 44% feel they don't normally have to wait too long to be seen compared with a CCG average of 55% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards, and 25 of these provided us with positive comments about the practice. Patients said they were supported emotionally as well as medically by friendly staff who listened to them. They said they could speak to a GP or nurse on the day they contacted the practice and same day appointments were available if required. One patient however commented that it was extremely difficult to access an appointment and it was not unusual to wait four weeks for a routine appointment.

During our inspection we spoke with 13 patients and a member of the patient participation group (PPG). Patients spoke positively of the practice and most told us they had no difficulty accessing urgent appointments.

Areas for improvement

Action the service SHOULD take to improve

- Update training records so all training is correctly recorded and updated training can be arranged appropriately.
- Check the understanding of chaperones so they stand in view of the patient during examinations.

Outstanding practice

- A professor of Dementia Studies reviewed all dementia referrals and the practice had secured funding for dementia advisors at the practice. An audit of read coding had increased the number of patients on the dementia register from 50 to 74 without clinical intervention.
- One of the GPs led research for the practice and had been involved in clinical trials since 1999. The GP was due to retire but was staying on in a research/clinical trial role until a GP was found with a particular interest in replacing them in this role.

Barlow Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice nurse specialist advisor and an expert by experience. An expert by experience is someone who uses health and social care services.

Background to Barlow Medical Centre

Barlow Medical Centre is a purpose built GP practice situated on a main road in the Didsbury area of south Manchester. There are three floors, the bottom two of which have patient consultation rooms. There is a passenger lift available so all areas are accessible to people with mobility issues. Car parking is available. The practice owned the building but another provider used some consulting rooms, usually when the practice was closed to patients.

The practice contracts with NHS England to provide General Medical Services (GMS) to the patients registered with the practice. At the time of our inspection 13,629 patients were registered. There was a much higher than average proportion of patients in the 25 to 34 age range. The practice is in an area of low deprivation and several doctors and professors are registered as patients.

There are seven GP partners (four male and three female) and a female salaried GP. The practice is a training practice and medical students and GP registrars attend the practice.

The practice is open from 8.30am until 6.30pm on Mondays, Tuesdays and Thursday, from 8.30am until 1pm on Wednesdays and from 8.30am until 5.15pm on Fridays. Consulting times are 8.30am until 1pm and 3pm until 6pm on Mondays, Tuesdays and Thursdays, 8.30am until 1pm on Wednesdays, and 8.30am until 1pm and 2pm until 5pm on Fridays. GPs start their telephone triage telephone calls to patients soon after 8am, as the telephone lines open at 8am.

The practice has opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours service.

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. This 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

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 July 2015. During our visit we spoke with a range of staff including GPs, practice nurses, a healthcare assistant, the practice manager and receptionists. We also spoke with 13 patients and reviewed 26 CQC comments cards.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Clinical staff were aware of how to report and record significant events. Reception and administrative staff told us they would inform the office supervisor of any incidents and there was also a recording form available on the practice's computer system. We saw evidence that significant events were an agenda item at the weekly practice meetings. The practice carried out an analysis of the significant events. Named staff members were given the responsibility for ensuring learning actions had been completed.

We reviewed safety records, incident reports and minutes of meetings where significant events had been discussed. The senior partner sent a management plan to staff every two weeks to show what stage the analysis and learning following a significant event was at. Lessons were shared to make sure action was taken to improve safety in the practice. For example, following an incident where the defibrillator was found to have been moved and oxygen used the practice ensured other providers using the building, who had used the emergency equipment, knew of the correct protocol and carried out their own investigation. All significant events were discussed at an annual meeting so any trends could be analysed.

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

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A GP was the lead member of staff for safeguarding, and they had completed training to level 3. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Safeguarding was an agenda item at the practice board meetings. Staff demonstrated they understood their responsibilities. Training information available during the inspection was not up to date. However, following the inspection the practice provided evidence that all staff had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that a chaperone was available if required. The practice manager told us that only the practice nurse and healthcare assistant acted as chaperones, and they had received training. Training for other staff had been arranged for other staff for 29 July 2015. The practice manager explained that after this date it would be decided who would chaperone. They would then request a Disclosure and Barring Service (DBS) check for these staff. 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 manager explained that a decision had been made not to have a DBS check for staff who did not have direct contact such as this with patients. However, some of the reception staff we spoke with told us they were occasionally asked to chaperone patients. They told us they stood either inside or outside the privacy curtains according to the wishes of the GP or patient. The confirmed they had not been trained but training had been arranged.
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were carried out. Fire alarms were tested regularly. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella. The building was relatively new and risks legionella risks were minimal.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and

tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place. Staff told us they had been trained in infection control but we saw no evidence of this. Hand washing training had been covered during the health and safety training all staff completed in May 2015. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. Informal checks on the standard of the cleaning were carried out and the practice manager liaised with the cleaning supervisor if required.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the eight personnel files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. These included proof of identification, references, qualifications, registration with the appropriate professional body and DBS checks for clinicians.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staffing was discussed at the weekly practice meetings and we saw locum GPs could be accessed at short notice in an emergency.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line 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 ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Results from 2013-14 were 92.7% of the total number of points available. Results to date showed this had increased to over 99%. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013-14 showed;

- Performance for diabetes related indicators were similar to expected for the clinical commissioning group (CCG) and national average with the highest indicator showing 99.37%.
- The percentage of patients with hypertension having regular blood pressure tests was below the expected CCG and national average at 72.01%. The practice provided evidence that this had improved and was now in line with expectations.
- Performance for mental health related indicators were mainly similar to expected for the CCG and national average with the highest indicator showing 90.57%. The practice provided evidence that the percentage of patients with physical and/or mental health conditions whose notes recorded smoking status in the previous 12 months was now 100%.
- The dementia diagnosis rate was slightly lower than expected for the CCG and national average at 78.57%

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been several clinical audits completed in the last two years, and we reviewed three of those. These related to Bisphosphonate treatment, laxative prescribing and atrial fibrillation. We saw clinical audit cycles had been completed to evidence improvements in practice and there were plans to further repeat audits. Findings from audits were used by the practice to improve services. The practice participated in applicable local audits and research.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff. This was an introduction to the practice. Training was then arranged
- 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 these learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff were responsible for recording their own training and we saw the records were not up to date. The training matrix had several gaps so it was not clear if staff had completed mandatory training such as safeguarding or basic life support. Following the inspection the practice provided evidence that the required training had taken place. 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 test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Good

Are services effective?

(for example, treatment is effective)

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. A professor of Dementia Studies reviewed all dementia referrals and the practice had secured funding for dementia advisors at the practice. An audit of read coding had increased the number of patients on the dementia register from 50 to 74 without clinical intervention. Palliative care meetings took place monthly and the practice worked closely with the local hospice.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. Practice nurses referred patients to a GP if they were unsure of their capacity to understand a consultation. If a child under the age of 16 attended without a parent staff notified the safeguarding lead. Clinical staff were aware of the Gillick competencies.

Health promotion and prevention

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

Practice nurses ran smoking cessation clinics, although the lead GP told us there was a lower than average percentage of the patient population who smoked. The practice nurses also ran travel health clinics and these were very well attended. An alcohol worker attended the practice to see patients approximately twice a week and a drug support worker also attended when required. The practice had a counselling room and staff from the mental health team used this for counselling sessions. Some patients were referred to 'walking trainers' that took place in local parks. However the lead GP explained that a high number patients had private gym membership.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 74.49%, which was lower than the CCG average of 81.73% and the national average of 81.86%. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93.8% to 97.5% and five year olds from 86.6% to 97.2%. Flu vaccination rates for the over 65s were 53.51%, and at risk groups 69.31%. These were also comparable to CCG and national averages.

Patients were able to access appropriate health assessments and checks. Patients over the age of 40 were invited to have their blood pressure checked. The healthcare assistant carried out this check and if patients were willing an over 40 NHS health check was carried out at the same time. The take up rate was not high, and the practice manager explained that they had found their patient population did not want to attend if they were well. Patients were therefore directed to a local pharmacy for a blood pressure check.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Of the 26 patient CQC comment cards we received 25 were positive about the service experienced. Most patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with a member of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. Patients also commented that their emotional needs, as well as medical needs, were looked after.

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

- 95% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.
- 82% patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and those identified as carers were being supported. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

Patients commented that they were offered a high level of emotional support, both by clinical and reception staff, when this had been required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area.

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

- The practice a telephone triage service starting at 8am. Patients could request calls at times to fit in with work commitments. Some clinicians offered weekend telephone appointments.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients or patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- Patients who had attended the A&E department were reviewed at clinical meetings to see if any additional support was required. However, A&E and walk in centre attendance rates were low.
- There were disabled facilities, hearing loop and translation services available.

Access to the service

The practice was open from 8.30am until 6.30pm on Mondays, Tuesdays and Thursday, from 8.30am until 1pm on Wednesdays and from 8.30am until 5.15pm on Fridays. Consulting times are 8.30am until 1pm and 3pm until 6pm on Mondays, Tuesdays and Thursdays, 8.30am until 1pm on Wednesdays, and 8.30am until 1pm and 2pm until 5pm on Fridays. Routine appointments could be booked up to six weeks in advance. Although there were no extended hours face to face appointments GPs did offer some telephone consultations during the weekend.

The majority of appointments were 15 minutes long. These had been introduced after GPs found they were often running late with 10 minute appointments. GPs ran a telephone triage service for patients requesting an urgent appointment. They started their telephone triage calls soon after 8am when the telephone lines opened. Patients were given an appointment on the same day if this was required. Patients telephoning before 9.30am received a call back from a GP the same day. If they telephoned after 9.30am they were told the call back could be the following day. However, if a patient said they had an urgent issue GPs ensured they received a call. Patients were able to request a call back at a particular time, for example so they could speak during a break at work. Patients could also request a telephone consultation to discuss test results.

Patients could request a home visit and if appropriate this was facilitated. Housebound patients were read coded so the necessity for a home visit was apparent. If a patient over the age of 80 requested a visit this was automatically arranged.

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

- 58% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 72% patients said they could get through easily to the surgery by phone compared to the CCG average of 67% and national average of 73%.
- 63% patients described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73%.
- 53% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.

However most of the patients we spoke with were able to get appointments when they needed them. Some commented that they might have to wait if they wished to see a particular GP.

Listening and learning from concerns and complaints

The practice had a 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 in the practice leaflet to help patients understand the complaints system and a complaints form was available at the reception desk. Some patients told us they were not aware of how to make a complaint but most said they would enquire at reception if they had any issues.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at the 29 complaints received between April 2014 and March 2015. We saw these were all dealt with in a timely way, and responded to appropriately. Complaints was an agenda item at practice meetings and there was also an annual meeting where complaints were analysed to look for trends. Lessons were learnt from 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 a mission statement which was displayed in the waiting areas and on the website 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
- There was a comprehensive understanding of the performance of the practice
- There was a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty. We found communication throughout the practice to be excellent.

Staff told us that regular team meetings were held. There was an annual staff away day and we saw the next one was planned for September 2015. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. 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. Staff also told us they regularly socialised outside working hours and the whole team, including clinicians, regularly met socially. It was evident that the team worked very well together.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. The practice had a patient participation group (PPG) that had been established since 2008. The group met every few months and meeting minutes were kept. There were currently eight members of the PPG and the practice tried to keep it to that number as it worked well. If a member left they advertised for another member. The group was asked for agenda items prior to meetings. The PPG were consulted about any changes to the practice. They were also able to suggest improvements. The PPG had suggested car park permits would ensure the car park was kept for patients and this suggestion had been implemented. The practice was considering carrying out a patient survey led by the PPG.

The practice had carried out a patient survey in 2014 and we saw they had put an action plan in place to address an issues found. The PPG had been involved in the action plan and monitored improvements made.

The practice monitored the NHS Choices website and the national GP patient survey so they were aware of the opinions of their practice population.

Innovation

There was a strong 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. One of the GPs led research for the practice and had been involved in clinical trials since 1999. The GP was due to retire but was staying on in a research/clinical trial role until a GP was found with a particular interest in replacing them in this role.