Brookfield Surgery

Quality Report

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Date of inspection visit: 16 August 2017
Date of publication: 29/09/2017

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brookfield Surgery on 16 August 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had systems to minimise risks to patient safety. However, we found some areas for improvement to maintenance of equipment, records of blank prescriptions, medicines and emergency equipment checks and monitoring and follow-up of uncollected prescriptions.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with 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 the majority of staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. The template for recording notifiable incidents did not support the recording of action taken under the duty of candour although there was evidence in complaints records this duty was met.

The areas where the provider should make improvement are:

- Take account of the duty of candour requirements and review the incident recording form so this supports the recording of action taken under the duty of candour.

Summary of findings

- Arrangements for minimising risk of infection should be reviewed in relation to the damaged phlebotomy chair.
- Review and improve arrangements for monitoring and follow-up of uncollected prescriptions.
- Systems to identify patients who are carers should be reviewed and improved.
- Continue to monitor and review the number of staff and mix of staff needed to meet patients' needs.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. The template for recording incidents did not support the recording of action taken under the duty of candour requirements where required although there was evidence in complaints records this duty was met.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- The practice had systems, processes and practices to minimise risks to patient safety. However we found some areas for improvement:
- The chair used for phlebotomy services was torn which may compromise effective cleaning.
- Arrangements to maintain medicines and emergency equipment checks in the practice nurses absence were not in place.
- Arrangements for monitoring and follow-up of uncollected prescriptions were not effective.

Are services effective?

Good

The practice is rated as good for providing effective services.

- There were no published results from the Quality and Outcomes Framework at the time of inspection due to the time the practice had been registered. However data from the practice showed high achievement in most areas. The practice had identified where improvements were required and were taking action to improve diabetes care.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Summary of findings

- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with 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 evidence from two examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and the majority of staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In two examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. They were referred to the Rotherham social prescribing team for assessment and support as required.

People with long term conditions

Good

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- There were no published results from the Quality and Outcomes Framework at the time of inspection due to the time the practice had been registered. However data from the practice showed high achievement in most areas. The practice had identified where improvements were required and were taking action to improve diabetes care.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their

Summary of findings

health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours with late evening appointments.
- 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 those with a learning disability.

Summary of findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice carried out advance care planning for patients living with dementia.
- The practice had been a dementia friendly practice since registration.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 July 2017. The results showed the practice was performing above local and national averages. 286 survey forms were distributed and 108 were returned. This represented 5% of the practice's patient list.

- 91% of patients described the overall experience of this GP practice as good compared with the CCG average of 86% and the national average of 85%.
- 86% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 78% and the national average of 77%.

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. Patients described the care they received as excellent or very good and the staff as caring, friendly and professional. Patients said the staff went the extra mile and commented positively about the GP and nurse consultations. They described the receptionists as helpful and felt they were always treated with respect.

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

Brookfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Brookfield Surgery

Brookfield Surgery is situated within a purpose built surgery in Valley Health Centre, Dalton. (The practice had a change of legal entity from partnership to sole trader in August 2016 so some data is not yet available.) The provider now is Dr Prabhu Shanmugam.

Brookfield Surgery is situated in a new purpose built premises known as Valley Health Centre. The premises are shared with another GP provider who is also the landlord.

The practice provides Personal Medical Services (PMS) for 2,090 patients in the NHS Rotherham Clinical Commissioning Group (CCG) area. The practice is situated in an area of high deprivation.

There is one male GP who is supported by a practice nurse and a health care assistant. There is a small administration team led by a practice manager. Locum GPs are used as required to support the practice.

The practice is open 8am to 6.30pm except on Tuesday when the practice is open until 7.30pm. Appointments are available 9am to 11.30am and 3.30pm to 5.30pm Monday, Tuesday and Wednesday, 9am to 11.30am Thursday and Friday 9.30am to 11.30am and 2.30pm to 5.30pm. Extended hours appointments are available 6.30pm to 7.30pm on a Tuesday.

When the practice is closed patients are diverted to the NHS 111 service from the practice telephone number.

This service is a teaching practice for medical students attending Sheffield University.

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as Rotherham Clinical Commissioning Group (CCG) to share what they knew.

We carried out an announced visit on 16 August 2017. During our visit we:

- Spoke with a range of staff (GP, practice nurse, health care assistant and reception and administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.

Detailed findings

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- A policy for incident reporting was in place and this had been reviewed in June 2016. Whilst this lacked detail about the types of incidents staff were expected to report, staff were well informed about the incident reporting system. They said they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice manager and the provider showed a good understanding of duty of candour requirements. (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) the recording form did not support the recording of action taken under the duty of candour requirements where required although there was evidence in complaints records this duty was met. However, we saw in complaints records patients had received an apology, an explanation had been given and a meeting had been offered.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out an analysis of the significant events and shared learning with staff.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, where there had been an incident relating to collection of a urine sample this had been investigated and areas for improvement identified. This had been discussed with staff and a memorandum had been sent out to all staff to confirm arrangements. We also saw where the practice had received a medical alert relating to recall of equipment this had been shared with the onsite pharmacy to ensure patient safety.

Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff and relevant information was displayed in surgeries. 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.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had told us they had received training on safeguarding children and vulnerable adults relevant to their role via eLearning and external events. We saw evidence from staff individual electronic records that they had recently completed training although this was not always reflected on the practice manager's overview used for monitoring training.The lead GP was trained to child protection or child safeguarding level three. The GP had developed a template to record consultations with patients under the age of 18 years to assist them in identifying any safeguarding concerns.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. Cleaning schedules were displayed and audits of cleaning were completed regularly.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol which had been reviewed and staff had received training via eLearning and external events.
- We saw that the patient chair used for phlebotomy had two small areas to the arms which had been covered in tape. This may compromise the effectiveness of the cleaning. We were told a quote had been requested for the chair to be recovered.

Good

Are services safe?

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. Staff told us they regularly checked if prescriptions had been collected by patients and would follow these up were they not collected within three months. However, when we checked a random sample we found four prescriptions which had not been collected within a three month period. Two of these prescriptions had notes for patients to make appointments on collection. We reported this to the GP who said they would review these immediately.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group (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 to monitor their use. However, records of receipt of boxes of prescriptions were not maintained to ensure the practice were aware of the stock held and to maintain a full audit trail. The staff reviewed this during the inspection and implemented a document to ensure this was completed.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We noted the practice had taken action following the failure of the vaccine fridge and had purchased a new fridge. Staff who monitored the temperatures of the fridge had an understanding of the role and reporting requirements. However, we did note that the temperatures were recorded as above the recommended range of eight degrees centigrade on four occasions since the new fridge had been put into operation. These instances had been reported by the practice to the screening and immunisations team and the manufacturers.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. However, the practice only had one practice nurse and during their leave tasks, such as medicines and emergency equipment checks, had not been completed. Patients were directed to community nursing teams or the walk in centre for treatments such as wound care when the practice nurse was on leave. Staffing in the reception and administration team had been low but two new members of staff were due to commence employment just after the inspection. A volunteer had also been recruited to assist the reception and administration team in some limited tasks. There was only one GP and locum GPs were used to support the practice as necessary. The provider was aware of the risks relating to the staffing at the practice and was considering their options in relation to future GP cover arrangements.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

- 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. 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. However, when the nurse was on leave the weekly checks of the equipment and medicines checks had not been completed.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The practice had employed a member of staff whose role was partly to assist in developing templates for the practice which included links to relevant alerts and guidance.
- The practice monitored that these guidelines were followed through audits and random sample checks of patient records.

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). As the practice had only been registered in its current form since August 2016 published QOF results were not available. The practice had submitted 2016/17 results and made these available to us during the inspection. The results showed high achievement across the majority of areas although the figures showed that achievement in areas related to diabetes care required further improvement. The provider had identified patient engagement with care and treatment for diabetes and the way the practice coded patients for exception reporting required improvement. (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). The practice had employed a member of staff for a few hours per month to specifically assist them in meeting QOF and other performance targets. The manager also checked patients records for those who had appointments booked for any relevant QOF alerts and identified these to the clinicians so any necessary care, treatment or tests could be opportunistically completed on the day or a further appointment made.

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits completed since registration where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken as a result included trying to improve the management of patients over 65 identified with an irregular heartbeat. This was because there had been little improvement between the first and second audit completed in this area and the practice was below the standards identified in national guidance. The provider had developed and implemented a practice protocol for the practice nurse and health care assistant to be more involved in the care of these patients and to opportunistically check for irregular pulse and arrange further investigations as required. In a second audit we reviewed the practice had identified patient uptake for cancer screening was low and had promoted patient participation and reviewed their coding of patient records by employing a member of staff to specifically look at this area. This audit also evidenced the practice had improved the suspected cancer national two week referral rate from 80% to 100%.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the practice nurse who was responsible for reviewing patients with long-term conditions had completed recent training in chronic obstructive pulmonary disease (COPD) and asthma.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. Staff had received an appraisal within the last 12 months.
- The most up to date training was not always reflected in the practice manager's training log which they used to monitor training. However, staff were able to evidence they had received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.

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

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

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- Shared care clinics for drug and alcohol misuse were held in the practice. Over 75 year old reviews, a falls clinic and a health trainer clinic were also hosted by the practice.
- The practice offered Disease Modifying Anti Rheumatic Drugs (DMARD), warfarin blood testing and monitoring and joint injections to reduce the need for patients to travel to hospital for these tests and treatments.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were not available at the time of the inspection due to the period the practice had been registered. The practice nurse told us they followed up patients who did not attend for vaccines and referred these to the health visitor where necessary.

The practice's uptake for the cervical screening programme had been audited. The practice had identified screening uptake could be improved and had promoted this in consultations and through advertising material displayed in the practice. This had resulted in improved uptake in all areas except breast screening, and the practice had

Good

Are services effective?

(for example, treatment is effective)

achieved well above the standards set. There were systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Equality and diversity training and confidentiality training was mandatory and completed annually.

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 and caring and treated them with dignity and respect.

We spoke with four patients including one member of the patient participation group (PPG). They told us they were extremely satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. They told us the GP and the nurse always had time for them and they felt listened to and receptionists were kind and helpful. We observed reception staff communicate in an enabling, caring and friendly manner with a patient who had difficulty expressing their needs. They took the time to ensure they fully understood the patients request and to ensure the patient understood the appointment made for them.

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

- 93% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 86%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 93% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 86%.
- 97% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average and the national average of 91%.
- 98% of patients said the nurse gave them enough time compared with the CCG average and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average and the national average of 97%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 96% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Good

Are services caring?

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 or above local and national averages. For example:

- 85% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.
- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 83% and the national average of 82%.
- 98% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89% and the national average of 90%.
- 96% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.
- For patients who were speech and hearing impaired the practice offered British sign language (BSL) interpreters who could be booked for consultations with doctors and nurses.

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. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 12 patients as carers (0.5% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. For example, carers could arrange appointments outside normal clinic times, if required, to accommodate their caring role.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

- The practice offered extended hours on a Tuesday evening until 7.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability. For example, double appointments for routine problems and 45 minute appointments for annual reviews.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning. The practice had been a dementia friendly practice since registration. Staff had received training to support patients living with dementia. Alerts identifying patients living with dementia were included on practice electronic systems and these patients were contacted to remind them of appointments.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services were available. For patients who were speech and hearing impaired British sign language (BSL) interpreters were offered.
- Online services were available and promoted by the practice. The practice told us 19% of their patients had registered for online services.

Access to the service

The practice was open 8am to 6.30pm except on Tuesday when the practice was open until 7.30pm. Appointments were available 9am to 11.30am and 3.30pm to 5.30pm Monday, Tuesday and Wednesday, 9am to 11.30am on Thursday and 9.30am to 11.30am and 2.30pm to 5.30pm on Fridays. Extended hours appointments are available 6.30pm to 7.30pm on a Tuesday.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. When the practice was closed patients were diverted to the NHS 111 service from the practice telephone number.

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

- 83% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average and the national average of 76%.
- 98% of patients said they could get through easily to the practice by phone compared with the CCG average of 72% the national average of 71%.

91% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average and the national average of 84%.

- 92% of patients said their last appointment was convenient compared with the CCG average and the national average of 81%.
- 86% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 51% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 61% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. They said they sometimes had to wait but felt this was because the GP was thorough in their consultations and they did not feel rushed.

The practice had a system to assess:

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available and displayed in the reception area to help patients understand the complaints system.

We looked at the two complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency. An explanation and an apology had been offered to the patient. Lessons were learned from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, parental responsibility for consent had been challenged by a member of staff which led to a complaint. The provider had shared learning about relevant parental consent with staff.

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 clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. The provider was aware of challenges to the practice and had put systems in place to assist them to meet the challenges. For example, they had employed a member of staff to regularly analyse performance to ensure the practice was working effectively.

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 and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, the GP was the safeguarding lead and the practice nurse was the infection prevention and control lead.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held regularly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice had a detailed risk log and action plans to minimise risk.
- We saw evidence from minutes of meetings that there was a structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the provider demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the provider was approachable and took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The provider encouraged a culture of openness and honesty. From the two complaints we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

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

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

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

Are services well-led?

Good

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

- Patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. For example, the PPG had looked at ways to address the non-attendance rates for medication reviews. The practice had since implemented text reminders for patients. They had also suggested ideas to improve confidentiality in the waiting area which had been implemented.
- The NHS Friends and Family test, complaints and compliments received.
- Staff through an annual staff survey 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 staffing on the reception and administration team had been low and they had discussed this with the manager and provider. We saw discussions with management on this subject had been recorded in annual appraisals. The provider had recruited a volunteer and employed two additional members of staff who were due to commence employment after the inspection to improve this area.
- 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 engaged in improving the performance and effectiveness of the practice. All the staff we spoke with were aware of their role in improving the performance of the practice.

The provider had developed a template in response to local events to record consultations for patients under the age of 18 years to assist them to identify and appropriately record any safeguarding concerns.