Castle Health Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Castle Health Practice on 28 June 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 clearly defined and embedded systems to minimise risks to patient safety.
- 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.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We saw one area of outstanding practice:

Nurses for the homeless, employed by the practice, delivered an outreach service to homeless patients registered at the practice. They responded to these patients by offering a flexible approach to working hours and locations. They regularly signposted patients to breakfast clubs which were run from the local homeless centre. The nurses had good links with this service. Where patients had not responded to calls, letters or

Summary of findings

appointments, practice staff made a welfare visit. The practice collected material donations of clothing, bedding and other such things and delivered them regularly to the homeless shelter.

The areas where the provider should make improvement are:

The practice should consider improving the identification of patients on the practice list who are carers. They should use this register of patients to identify and offer systems of support to them.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- 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.
- There was a security guard on duty at the practice seven days per week to ensure the safety of staff and patients. The practice had a number of patients on its list classified as violent patients (that is, they had previously exhibited violence in a health care setting).

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or below average compared to the national average. However, this practice figure had risen from 93% (2015/2016) to 98% (2016/2017) of available QoF points, within a year.
- 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 and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved, both internally and externally, including social care, multidisciplinary agencies and voluntary agencies.

Summary of findings

- The practice employed two Nurses for the Homeless who provided outreach support.

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 from information in the waiting room. Staff also signposted patients to services.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- We were told about several examples where the practice had gone above the standard expected in order to care for its patients. For example, the practice escorted a patient to a hospital appointment in a taxi, paid for by the practice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, one of the GPs had a special interest in substance misuse and used their links, experience and knowledge to deliver better care to patients.
- 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 and long term conditions.
- Many of these patients were added to the practice's palliative care register, including those with conditions other than cancer.
- 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 was open seven days a week, with the exception of bank holidays.
- 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 11 examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

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

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about their responsibilities in relation to this.
- There was a leadership structure and 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.
- 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 15 examples we reviewed we saw evidence the practice complied with these requirements.
- The practice 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 patients and we saw examples where feedback had been acted on. The practice did not have a patient participation group, but was working hard to try and set this up. It found alternative ways of engaging patients where possible, for example by conducting regular patient surveys.
- There was a focus on continuous learning and improvement. Staff training and supervision was a priority and was built into staff rotas on a weekly basis.

GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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. (This group formed just 7% of the practice population.)

- The practice had fewer patients in this population group compared to the national average.
- 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 had an approach of undertaking welfare visits to older patients who did not respond to communication from the practice.
- 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. For example, an over 75-years health check.

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.
- Nationally reported data for 2015/2016 showed the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c (a blood result which indicates diabetic control) was 64 mmol/mol or less in the preceding 12 months was 85%, compared with the CCG average of 80% and the England average of 78%.

Summary of findings

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

Families, children and young people

Good

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

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- 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 and for acute pregnancy complications. All under five year olds were offered same day appointments.
- The practice regularly liaised with attached health visitors when babies and children failed to complete their vaccination programme.

Summary of findings

- The practice adopted 'was not brought' guidelines from the local safeguarding team ensuring clinicians were responsible for the follow up of those children who missed appointments.

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, the practice was open seven days per week, from 8am-8pm.
- 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.
- There was a 'text and remind' messaging service and the practice was developing this further to enable patients to cancel appointments using this system.
- There were protected 'five-day-worker' appointments to enable working age people better access to appointments, if they were in full-time employment.

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.

- 2% of the practice patient list were considered to be homeless at the time of inspection.
- There was a high prevalence of drug and alcohol misuse and this contributed to the vulnerability of some patients.
- Just over 1% of the practice list were Syrian refugees who had experienced physical and/or psychological trauma.
- The practice was commissioned to register AMS (Alternative Medical Services) patients. These were patients who had been unable to be cared for at other practices due to violent behaviour within a health care setting.
- AMS patients made up just less than 1% of the practice patient list.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Summary of findings

- The practice offered longer appointments for patients with a learning disability as well as refugees and those with complex long term conditions.
- 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.
- Much of the care for these patients was done via the practice's nursing outreach service.
- 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.
- The practice held vulnerable families meetings and invited other relevant agencies.

The practice collected clothing donations for a nearby homeless centre and regularly delivered these to the centre.

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.
- 100% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- One staff member was a dementia champion and signposted other staff to best resources.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice had significantly reduced its prescribing of a particular hypnotic medication.
- Nationally reported data from 2015/2016 showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 90%. This was comparable to the CCG average of 92% and England average of 89%.

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- Patients with dementia who found it difficult to leave their home were offered a review by home visit.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with local and national averages. 352 survey forms were distributed and 82 were returned. This represented 3% of the practice's patient list and a response rate of 23% (national average response rate was 38%)

- 94% of patients described the overall experience of this GP practice as good compared with the CCG average of 90% and the national average of 84%.
- 86% of patients described their experience of making an appointment as good compared with the CCG average of 80% and the national average of 73%.
- 85% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards which were all positive about the standard of care received. Patients commented that receptionists, GPs and nurses were polite, courteous, caring and helpful.

We distributed CQC questionnaires to patients during the inspection. Ten questionnaires were distributed but only one was returned. This patient said they were satisfied with the care they received and thought staff were caring. The most recent Friends and Family data (May 2017) indicated that from 17 respondents, 16 would be 'extremely likely' or 'likely' to recommend the practice to friends or family.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

The practice should consider improving the identification of patients on the practice list who are carers. They should use this register of patients to identify and offer systems of support to them.

Outstanding practice

We saw one area of outstanding practice:

Nurses for the homeless, employed by the practice, delivered an outreach service to homeless patients registered at the practice. They responded to these patients by offering a flexible approach to working hours and locations. They regularly signposted patients to breakfast clubs which were run from the local homeless centre. The nurses had good links with this service. Where patients had not responded to calls, letters or appointments, practice staff made a welfare visit. The practice collected material donations of clothing, bedding and other such things and delivered them regularly to the homeless shelter.

Castle Health Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Castle Health Practice

Castle Health Practice, Scarborough, YO11 2NP, is a GP practice situated in the heart of Scarborough town centre, among an area of high street shops. It is situated close to train and bus links but has no free or accessible parking attached to its premises.

Housed in a premises owned by Boots UK Limited, the property is leased to the practice by NHS property services. Castle Health Practice is owned and managed by the provider, IntraHealth, who operate a network of GP practices throughout the UK.

There are two regular salaried GPs, one is male and one is female. There are in addition some regular locums provided by IntraHealth and the practice is hoping to recruit another salaried GP in the near future. There is an Advanced Nurse Practitioner (ANP) as well as two practice nurses (one with a dual role of ANP and practice nurse) and a health care assistant. There are also two nurses for the homeless. The practice nurse undertakes an ANP role for a few sessions per week. The nurses are all female. Nearly all clinical and non-clinical staff work part-time hours. In addition, there are a number of receptionists, administrative and phlebotomy staff as well as a practice manager who was on an extended period of leave at the time of our inspection. As such, the practice is currently being managed by temporary acting practice managers with regular support from an IntraHealth primary care manager based in Durham, north east of England. In addition, an ANP is temporarily acting as practice manager for a few hours per week. There are 19 staff in total, including the GPs.

The practice is open seven days per week from 8am until 8pm and many of the practice staff cover the weekend rotas. Appointments are available from 8am and the last appointment slot of the day is usually 7.30pm. Outside of these hours patients can receive care at the urgent care centre within Scarborough Hospital by telephoning NHS 111 service.

The practice patient list size is currently 3022. The practice population is very transient and the list size can change very frequently. The practice score on the Index of Multiple Deprivation (IMD equals one) indicates high levels of deprivation. People living in more deprived areas tend to have greater need for health services. The lower the Indices of Multiple Deprivation (IMD) decile, the more deprived an area is. The practice has a high number of patients with known drug and alcohol problems. It is commissioned by NHS England to treat AMS patients (those who have been excluded from other GP lists due to violent behaviour in a health setting). There are a significant number of patients who are homeless registered with the practice. There is a nearby university and the practice offers outreach facilities to many of the students there. There are a considerable number of Syrian refugees registered at Castle health practice who have experienced psychological and physical trauma before arriving in the UK.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, for example the local clinical commissioning group, to share what they knew. We carried out an announced visit on 28 June 2017. During our visit we:

- Spoke with a range of staff (GPs, nurses, receptionists, secretaries and practice managers) and spoke to patients who used the service.
- Observed how patients were being cared for in the reception area.
- 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.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, when a vaccination was administered in error by a nurse, a GP was able to reassure the patient that there was no clinical risk on that occasion. However, this error also brought about a change in clinical practice where the nurses began to meet as a group every week for peer discussion about any forthcoming immunisations, and any action required. This was protected time for the nurses and facilitated safer practice.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

- The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety. On the day of inspection managers were open about the themes they had identified from significant events and had plans in place to continue to minimise any potential risks.
- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies were very accessible to all staff but didn't clearly outline who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of documented examples we reviewed we found that the Advanced Nurse Practitioner attended safeguarding meetings when possible and provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and ANPs were trained to child protection or child safeguarding level three. A notice on all clinic room doors advised patients that chaperones were available if required. Male chaperones were also routinely offered to patients, as well as female chaperones. 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.
- 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 and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. On the day of inspection the practice had not labelled the due date for change of its privacy curtains, and staff were unclear how they would be laundered or changed. The practice started to rectify this immediately, as a result of our inspection.

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. The majority of medications were transferred to the next door pharmacy via EPS (electronic prescribing system). The practice carried out some medicines audits, with the support of the CCG pharmacist, 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. Three of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.
- The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse).

We reviewed four 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. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice held monthly 'drills' for retrieving emergency equipment. This was a timed exercise and staff were chosen at random to ensure that all were able to competently assist in the event of an emergency.

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. This plan had been effectively put into place following a recent national NHS cyber-attack on computer systems.

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 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 used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results 2015/2016 showed that the practice had achieved 93% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 95%. However, the practice had recently received its 2016/2017 QoF results, indicating an improvement of 5% on the previous year.

Exception rates for clinical domains or indicators such as diabetes and mental health were significantly higher than the CCG or national averages. (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 analysed this variation and felt the results were attributed to the demographic makeup of the practice patient list. Within the context of a transient, in some cases homeless, population with additional vulnerabilities we saw evidence that missed appointment rates were very high and sometimes health reviews were not a priority for some patients.

Performance for diabetes related indicators was similar to the CCG and national averages:

- Nationally reported data for 2015/2016 showed the percentage of patients with diabetes, on the register, in whom the last IFCCHbA1c (a blood result which indicates diabetic control) was 64 mmol/mol or less in the preceding 12 months was 85%, compared with the CCG average of 80% and the England average of 78%.
- The practice exception rate for this was 32%, compared with the CCG and national average exception rate of 12%

Performance for mental health related indicators was similar to the CCG and national averages:

- Nationally reported data from 2015/2016 showed that the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 90%. This was comparable to the CCG average of 92% and England average of 89%.
- The practice exception rate for this was 16%, compared with CCG average exception rate of 15% and the national average of 13%.

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last two years, both of these were completed audits 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; the vast reduction of the prescribing of a high risk hypnotic medication in substance misuse patients. This was done by a managed detoxification programme and as a result improved safety for those patients.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.

Good

Are services effective?

(for example, treatment is effective)

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a 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, however this wasn't always undertaken using written consent formats. For example, when carrying out minor surgical procedures, written consent forms were not completed but clinicians did consistently record in the patient record that consent had been obtained. Following our inspection, we were provided with information that this had been addressed.

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those 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 and those requiring support from the local homeless shelter.
- A dietician and a smoking cessation adviser were available on the premises.

The practice's uptake for the cervical screening programme was 84%, which was comparable with the CCG average of 84% and the national average of 81%. The exception rate for this indicator was 14%, higher than the CCG and England averages of 6%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates

Good

Are services effective?

(for example, treatment is effective)

for the vaccines given were comparable to CCG and national averages. For example, rates for the vaccines given to under two year olds ranged from 89% to 94% and five year olds from 88% to 97%.

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

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.
- Patients could be treated by a clinician of the same sex.
- Chaperones were offered to both male and female patients, routinely.

All of the seven patient Care Quality Commission comment cards we received were positive about the service experienced. Patients commented that receptionists, GPs and nurses were polite, courteous, caring and helpful.

We spoke with one patient. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We were told about several examples where the practice had gone above the standard expected in order to care for its patients. For example, when a patient had repeatedly failed to attend the hospital for a cytology appointment, the practice made a further appointment and escorted the patient in a taxi, paid for by the practice.

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:

- 86% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 86% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 92%
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 92% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 94% and the national average of 91%.
- 96% of patients said the nurse gave them enough time compared with the CCG average of 95% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 84% of patients said they found the receptionists at the practice helpful compared with the CCG average of 90% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, the local CCG held quarterly contract meetings and they reported that the practice always attended these meetings, providing good communication about the leadership and vision of the practice.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals. Outreach services were offered to students at the nearby university which were tailored to their needs. The practice completed an under 16s sexual health risk assessment tool where young people were seeking contraceptive advice and support, and were under the age of 16.

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 local and national averages. For example:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 86%.
- 77% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 92% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 93% and the national average of 90%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%

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

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

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 39 patients as carers (approximately 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. The practice also had awareness that some of its patients had nobody caring for them, due to lifestyle factors, and that some of these patients were extremely socially isolated from any network of support. The practice ensured it signposted these patients to relevant caring organisations also.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

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

Responding to and meeting people's needs

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

- The practice offered extended hours every evening until 8pm for working patients who could not attend during normal opening hours, seven days per week.
- There were longer appointments available for patients with a learning disability, for refugees and those patients with complex pathology who were difficult to reach.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children under five years old and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had installed a lift to improve access.
- The practice made a 'welfare' home visit to patients whose lack of response to communication appeared unusual.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice worked closely with specialist drug and alcohol services to offer a good standard of care to patients with substance misuse.
- Patients on the AMS contract list (for violence within a healthcare setting) were offered the same flexibility of appointments due to the practice providing seven day security personnel.
- Nurses for the homeless delivered an outreach service to homeless patients registered at the practice. They responded to these patients by offering a flexible approach to working hours and locations. They regularly signposted patients to breakfast clubs which were run from the local homeless centre. The nurses had good links with this service. Where patients had not responded to calls, letters or appointments, practice staff made a welfare visit. The practice collected material donations of clothing, bedding and other such things and delivered them regularly to the homeless shelter.

Access to the service

The practice was open between 8am and 8pm Monday to Sunday, with the exception of bank holidays. Appointments were from 8am until 7.30pm daily. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

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

- 92% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 85% and the national average of 76%.
- 94% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 74% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 78% and the national average of 76%.
- 97% of patients said their last appointment was convenient compared with the CCG average of 96% and the national average of 92%.
- 86% of patients described their experience of making an appointment as good compared with the CCG average of 80% and the national average of 73%.
- 66% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 50% 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system to assess:

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

Receptionists handling calls requesting home visits were offered a telephone consultation from a GP who would clinically assess the need for a home visit. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

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

We looked at 11 complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, when a patient was unhappy about the way they were spoken to by a member of the reception team, a full apology was given by the practice. At the next receptionist meeting, staff received an update and reminder about the need for sensitivity and customer service skills when talking to patients.

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, developed by the provider, which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a 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 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.
- 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 monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous 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, just days before our inspection, the practice reported a problem with door security to the landlord of the premises and continued to chase up a solution in order to minimise risks.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the management team 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 GPs and managers were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. A culture of openness and honesty was encouraged. From the sample of 15 documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

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

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported by managers. All staff were involved in discussions about how to run and develop the practice. IntraHealth (the provider) 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 regular questionnaires and surveys. The practice did not have a patient participation group (PPG) and although it had tried to establish one, this effort had failed on numerous occasions.
- the NHS Friends and Family test, complaints and compliments received
- Staff, through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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 prioritised improve outcomes for patients in the area. The practice had been feeling the impacts of high maternity and sickness absence rates in the preceding months. As such, the leadership was being provided from a variety of sources which at times felt confusing for some staff. Additional locum and bank staff were supporting clinical practice. Despite this, the practice team remained focussed on the needs of the patients and had improved on its quality outcomes. The local CCG was satisfied with the range of leadership support being provided at the practice and this was reflected in positive comments and survey results from patients.