

Lime Tree Surgery

Quality Report

321 High Road
Leytonstone
E11 4JT
Tel: 020 8519 9914
Website: www.limetreesurgery.org.uk

Date of inspection visit: 9 May 2017
Date of publication: 18/07/2017

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

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	11
Areas for improvement	11

Detailed findings from this inspection

Our inspection team	12
Background to Lime Tree Surgery	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	14

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lime Tree Surgery on 9 May 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Data showed that practice achievement for cervical cytology, immunisations for five year olds and bowel screening was below the CCG and national averages.
- 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.
- All staff had completed mandatory training in line with their role; this included safeguarding children, fire training and chaperoning.

- 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, however results from the GP Patient Survey did not support this and were low in relation to making and obtaining an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

Summary of findings

- The patient participation group was active and they purchased a defibrillator for the practice from monies they raised from fundraising.

The areas where the provider should make improvement are:

- Continue to work to improve patient satisfaction with access to services including getting through to the practice by telephone and obtaining an appointment.

- Continue to work to increase the uptake of cervical cytology, childhood immunisations and bowel screening.

Review the process for recalling patients with mental health illnesses to increase the uptake of annual reviews.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- 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 held regular meetings where learning from significant events and patient safety alerts were discussed and shared.
- 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.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were mostly comparable to the CCG and the national averages.
- Data showed that cervical cytology, immunisation rates for five year olds and bowel screening rates were lower than the CCG and national averages.
- 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.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data from the national GP patient survey showed patients rated the practice comparably to the CCG and national averages 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.
- The practice had identified less than 1% of its patient as being a carer.

Are services responsive to people's needs?

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. However results from the GP patient survey did not support this view.
- The practice had extended hours appointments on two evenings a week and was a part of the local HUB which provided appointments on weekday evenings and weekends when the practice was closed.
- 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.

Good



Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Good



Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had 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 one example 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, which was very active.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- 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

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.
- These patients were offered an annual review and had a named GP.
- 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.

Good



People with long term conditions

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- 78% of patients with diabetes had a record of a foot examination and risk classification documented in their records compared to the CCG average of 80% and the national average of 88%. The practice had an exception reporting rate of 4%, which was lower than the CCG average of 6% and the national average of 8%.
- 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.

Good



Summary of findings

- 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.
- The practice held health promotion events for these patients.

Families, children and young people

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

- From the sample of two 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 low for immunisations for five year olds.
- 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.
- There was a GP with a specialist interest in womens health who carried out six week baby checks.
- The practice had a dedicated room for breastfeeding.

Good



Working age people (including those recently retired and students)

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

- The needs of 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.
- Telephone consultations were available each day.
- The practice was signed up to the local HUB which provided appointments on weekday evenings and weekends when the practice was closed.

Good



Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, refugees 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.
- These patients were offered an annual review.
- 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.

Good



People experiencing poor mental health (including people with dementia)

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

- The practice carried out advance care planning for patients living with dementia.
- 76% of with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive agreed care plan documented in the record compared to the CCG average of 91% and the national average of 89%.The practice had an exception reporting rate of 3%, which was lower than the CCG average of 7% and the national average of 13%.
- The practice had a policy to not exception report these patients unless there were extenuating circumstances.

Good



Summary of findings

- The practice specifically considered the physical health needs of patients with poor mental health and dementia and gave these patients longer appointments to give enough time to discuss their complex needs.
- 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 in July 2016. The results showed the practice was sometimes performing below local and national averages. Three hundred and fifty five survey forms were distributed and 107 were returned. This represented 1.4% of the practice's patient list.

- 76% of patients described the overall experience of this GP practice as good compared with the CCG average of 75% and the national average of 85%.
- 43% of patients described their experience of making an appointment as good compared with the CCG average of 65% and the national average of 73%.
- 66% 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 67% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards which were all positive about the standard of care received. There was a recurring theme of friendly, thoughtful caring staff members.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice took part in the Friends and Family Test, during a three month period 55 surveys were completed 71% of patients stated they would be extremely likely to recommend the practice and 29% stated they would be likely to recommend the practice. There were no patients who stated that they would not recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- Continue to work to improve patient satisfaction with access to services including getting through to the practice by telephone and obtaining an appointment.
- Review process for identifying patient carers to ensure that all carers receive the support that is available.
- Continue to work to increase the uptake of cervical cytology, childhood immunisations and bowel screening.
- Review the process for recalling patients with mental health illnesses to increase the uptake of annual reviews.

Lime Tree Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was supported by a GP specialist adviser.

Background to Lime Tree Surgery

Lime Tree Surgery is located in a converted building in a residential area of East London and is a part of Waltham Forest Clinical Commissioning Group (CCG).

There are 7,500 patients registered with the practice, 50% of which are aged between 25 and 49, 12% of patients are aged over 60 and 14% of patients are aged between 0 and 9 years old. The practice has a deprivation score of 31, which is similar to the CCG average of 30 and higher (more deprived) than the national average of 22. The practice has two residential homes that it provides primary care services to.

The practice has one male GP partner and two female salaried GPs who carry out a total of 20 sessions per week. The practice is a teaching and training practice and has four trainees who carry out a total of 17 sessions per week. There is a practice nurse who does seven sessions per week and a physician's associate who carries out eight sessions per week. The practice has a practice manager, an assistant practice manager and eight reception/administration staff members.

The practice operates under a Personal Medical Services (PMS) contract (a locally agreed alternative to the standard GMS contract used when services are agreed locally with a practice, which may include additional services beyond the standard contract).

The practice is open Monday to Friday between 8:30am and 6:30pm except Thursdays when it closes at 1:30pm. Phone lines are answered from 8:30am and appointment times are as follows:

- Monday 8:30am to 12:30pm and 2pm to 8pm
- Tuesday 8:30am to 12:30pm and 2pm to 8pm
- Wednesday 8:30am to 12:50pm and 2pm to 7:30pm
- Thursday 9:20am to 12:30pm
- Friday 8:30am to 5:50pm

The locally agreed out of hours provider covers calls made to the practice when the practice is closed.

The Lime Tree Surgery operates regulated activities from one location and is registered with the Care Quality Commission to provide diagnostic and screening procedures, treatment of disease, disorder or injury and maternity and midwifery services.

Why we carried out this inspection

We inspected this service as part of our comprehensive programme. This service had not previously been inspected.

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

Detailed findings

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 a residential home to share what they knew. We carried out an announced visit on 9 May 2017. During our visit we:

- Spoke with a range of staff including, GPs, a nurse, management and reception/administration staff members. We also spoke with patients who used the service and a manager at a local care home where the practice has registered patients.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

- 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.

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 and a form that gives step by step instructions on what to do in the event of a significant event. 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 two documented examples out of seven events in the past 12 months. 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, we viewed a significant event about blood test results being sent to another practice with a similar name. We saw that the practice contacted the hospital requesting that the error be corrected to prevent recurrence, the CCG was informed of the incident and all affected patients were contacted and given an explanation and apology. The practice discussed this at a practice meeting where measures were agreed to ensure early detection for if this incident were to occur again, this included putting a process in place to monitor that all blood test results were received by the practice within seven days. In cases where blood test results were not received within the seven day time period a staff member would follow up with the hospital.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff on the practices computer system and also in hard copy. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP was the lead member of staff for safeguarding. From the sample of one documented examples we reviewed we found that the GP 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 were trained to child protection level three, nurses were trained to level two and non-clinical staff were trained to level one.
- A notice in the waiting room and all consultation rooms 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.
- The GP was the infection prevention and control (IPC) clinical lead who with the support of the practice manager 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.

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).

Are services safe?

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions (PGD) (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- 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 and staff booked annual leave in advance 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.

We reviewed three 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 alarm testing and annual 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.
- There was an instant messaging system on the computers in the practice 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 had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and copies were kept offsite to access in case of limited access to the practice building.

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 and patient safety alerts.

- 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 discussions at meetings.
- All patient safety alerts were emailed to the relevant staff who signed a copy in a folder as acknowledgement, the practice kept an action plan of all relevant alerts and the actions and outcomes were discussed at practice meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 93% of the total number of points available compared with the clinical commissioning group (CCG) and national average of 95%. The practice had an overall exception reporting rate of 10%, which was higher than the CCG average of 7% and the national average of 6% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice sometimes performed lower than the CCG and national averages for some QOF clinical targets; however their exception reporting rates were lower in some areas than the CCG and national averages. Data from QOF showed:

- Performance for diabetes related indicators was comparable with the CCG and national averages. For example 78% of patients with diabetes had a record of a foot examination and risk classification documented in

their records compared to the CCG average of 80% and the national average of 88%. The practice had an exception reporting rate of 4%, which was lower than the CCG average of 6% and the national average of 8%.

- Performance for mental health related indicators was lower than the CCG and national averages. For example 76% of with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive agreed care plan documented in the record compared to the CCG average of 91% and the national average of 89%. The practice had an exception reporting rate of 3%, which was lower than the CCG average of 7% and the national average of 13%.

The practice were aware of its' low scores in relation to mental health, we saw that a recall system was in place, where these patients had ongoing recalls in place in the form of letters and phone calls, which was over and above the QOF requirements of three recalls before a patient was exception reported. All patients who had not had their care plan reviewed had a pop up alert put on their system to alert any staff member to book the appointment for this when they contacted the practice or for the clinician to carry this out opportunistically if the presented at the practice for a different medical reason. We also noted that the practice had a policy to not exception report these patients unless there were extenuating circumstances.

There was evidence of quality improvement including clinical audit:

- There had been seven clinical audits commenced in the last two years, three of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, the practice carried out an audit with the aim of reducing antibiotic prescriptions for 'common infections' which were likely to be viral and self-limiting. We saw that before the audit commenced the GPs agreed to introduce a patient information leaflet to their consultations advising patients of why antibiotics were inappropriate and what could be done instead. The first audit showed that 28% of patients presenting with a sore throat were not given antibiotics, 72% of patients were given antibiotics and one patient was given a delayed prescription for antibiotics. The second audit after the patient information leaflet was introduced showed that 40% of patients presenting with a sore

Are services effective?

(for example, treatment is effective)

throat were not given antibiotics, 60% were given antibiotics, there was one delayed antibiotic prescription and three documented incidences of when the patient information leaflet was used. The results were discussed at a clinical meeting, where it was agreed that better documentation of consultations and consistency in the using of read codes was needed and clinicians were encouraged to continue with the use of the leaflet to help reduce unnecessary antibiotic prescriptions.

Information about patients' outcomes was used to make improvements such as: maximising the use of in-house expertise such as gynaecology and women's health and respiratory health to reduce the need for hospital referrals especially for conditions that have a high rate of patients missing their appointments.

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 clinical and non-clinical staff members. 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 and giving childhood immunisations.
- 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 attendance at updates and nurses forums, 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, 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 five 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.

- 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.

Are services effective?

(for example, treatment is effective)

- The process for seeking consent was monitored through discussions at clinical meetings.

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, patients with cancer, homeless patients, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- A dietician was available from a local support group and smoking cessation advice was available on the premises.

The practice's uptake for the cervical screening programme was 67%, which was lower than the CCG and the national average of 81% and the national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice were actively trying to increase their uptake of cervical cytology and produced a business case which enabled the CCG to employ a member of staff to work at the practice whose sole focus on cytology. This member of staff contacted all 502 women who were identified as requiring cytology screening and booked 80 appointments 28 of which the patients did not turn up for. The practice made a video which was played in the reception area and was aimed at different ethnicities to encourage patients to book an appointment for the screening or to book an appointment to discuss concerns, and they were working with local mosques to educate women on the importance of screening.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. For example, 67% of female patients aged between

50 and 70 years old had been screened for breast cancer in the past three years compared to the CCG average of 69% and the national average of 73%. Thirty two percent of patients aged 60 to 69 were screened for bowel cancer in the past 30 months compared to the CCG average of 49% and the national average of 58%. The practice displayed promotional material around the practice to encourage the uptake of bowel screening, we viewed a random sample of three patients who had not completed the bowel screening test, we saw that there was an alert on their record informing of this and this was also discussed in their consultations where we noted that they were encouraged to complete this.

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.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given to under two year olds were comparable to CCG/national averages. For example, rates for vaccines ranged from 82% to 90% compared to the national average of 90%. Rates for vaccines for five year olds from 74% to 76%, which was lower than the CCG average of 77% to 89% and the national average of 88% to 94%.

The practice was aware of their low vaccine rates to address this, the practice played videos promoting childhood immunisation in the patient waiting area and posters were displayed and leaflets were made available in the waiting area and were also given during consultations. There was a recall system, which included telephone calls as well as letters being sent, pop up alerts were put on the records of all children that needed an immunisation to alert all staff members to book a appointment or opportunistically immunise the patient. When a patient refused an immunisation or was apprehensive about booking an appointment, an appointment was booked with the GP to discuss any concerns.

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.

All of the 17 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

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

- 87% of patients said the GP was good at listening to them compared with the CCG average of 83% and the national average of 89%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and the national average of 95%.
- 83% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78% and the national average of 85%.

- 88% of patients said the nurse was good at listening to them compared with the CCG average of 86% and the national average of 91%.
- 88% of patients said the nurse gave them enough time compared with the CCG average of 87% and the national average of 92%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 94% and the national average of 97%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 91%.
- 76% of patients said they found the receptionists at the practice helpful compared with the CCG average of 83% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, the manager of a local residential care home where some of the practice's patients lived all praised the care provided by 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.

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:

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 79% 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 CCG average of 74% and 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 85% and the national average of 90%.

Are services caring?

- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 80% 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. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Health promotional videos were played in the patient waiting area.
- There were displays in the patient waiting area advertising which type of clinician dealt with which ailments and also the specialities of the clinician, so patients were informed about who to book an appointment with.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. 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 84 patients as carers. Written information was available to direct carers to the various avenues of support available to them. Carers were offered an annual health check and flu vaccination and older carers were offered timely and appropriate support. The practice was actively trying to increase its number of registered carers, we saw that asking whether a patient was or has a carer was incorporated into the registration form, posters were displayed around the practice and patients who required extra support were asked whether they had a carer or required one. The practice was working with a carers charity to raise awareness of what a carer is and reduce the stigma attached to registering as a carer if you were a spouse or a family member as well as providing an avenue for support. The charity also helped the practice put an action plan in place. The practice also worked with its patient participation group and carers charities to provide awareness days where patients were invited to the practice to receive support and information about being a carer.

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

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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered extended hours on a Monday and Tuesday evening until 8pm and on a Wednesday 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.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS, those only available privately were referred to other clinics.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice had a lift to improve access to all floors.
- The practice had implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- The practice held every other patient participation (PPG) meeting on a Saturday to enable working patients to attend.

Access to the service

The practice was open Monday to Friday between 8:30am and 6:30pm except Thursdays when it closed at 1:30pm. Phone lines were answered from 8:30am and appointment times were as follows:

- Monday 8:30am to 12:30pm and 2pm to 8pm

- Tuesday 8:30am to 12:30pm and 2pm to 8pm
- Wednesday 8:30am to 12:50pm and 2pm to 7:30pm
- Thursday 9:20am to 12:30pm
- Friday 8:30am to 5:50pm

The locally agreed out of hours provider covered calls made to the practice when the practice was closed.

In addition to pre-bookable appointments that could be booked up to three 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 local and national averages.

- 75% of patients were satisfied with the practice's opening hours compared with the CCG average of 72% and the national average of 76%.
- 33% of patients said they could get through easily to the practice by phone compared to the CCG average of 61% and the national average of 73%.
- 72% 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 79% and the national average of 85%.
- 83% of patients said their last appointment was convenient compared with the CCG average of 88% and the national average of 92%.
- 43% of patients described their experience of making an appointment as good compared with the CCG average of 65% and the national average of 73%.
- 31% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 45% and the national average of 58%.

The practice were aware of their low patient satisfaction scores with patients being able to get through to the practice by telephone, patient experience with making an appointment and waiting times to be seen. As a result of the patient survey the practice carried out training with reception staff members and completed a two cycle audit looking at the number of attempts it took patients to get through to the practice by phone and how many rings it took before a telephone call was answered. The first audit showed that 17% of patients got through to the practice within one to five rings, 35% got through within six to 10 rings, 31% within 11 to 20 rings, 16% within 21 to 30 rings and 1% within 31 to forty rings. The second audit showed

Are services responsive to people's needs?

(for example, to feedback?)

70% of patients got through to the practice within one to five rings, 17% within six to 10 rings, 10% within 11 to 20 rings and 3% within 21 to 30 rings. The audit also showed that there was an improvement in the number of rings it took before the phone was answered, which went from 40% being answered within zero to six rings to 77%. The practice actively promoted online GP access and achieved a 37% uptake and the practice's multimedia system was used to resolve challenges with access.

The practice also ensured that patients were aware of the waiting time of each clinician so that patients knew what to expect.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

Reception staff would inform the GP when a request for a home visit was made; the GP would then contact the patient to assess the urgency of the 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.
- The practice manager was responsible for handling all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

We looked at two out of six complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example we viewed a complaint letter from a patient who was unhappy that they received a did not arrive letter for an appointment that they did attend but found that the practice was closed. We saw that the patient received an apology and an explanation and this was discussed at a practice meeting where it was agreed to put notices up inside and outside of the practice advising patients to ring the practice bell when they have an appointment at a time when the practice doors are closed.

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 and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored; all staff members were involved in strategy meetings.

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 as well as the roles of their colleagues. GPs and nurses had lead roles in key areas such as long term conditions.
- Practice specific policies were implemented and were available to all staff on the computer system and hard copy. 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, such as a monthly health and safety risk assessment.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints, all staff members were involved in these meetings.

Leadership and culture

On the day of inspection the GP partner and management team in the practice 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 GP partner was approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of one documented example 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 and we saw evidence of this.
- 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. We noted team away days were held every 12 months. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the management team and the GPs. All staff were involved in discussions about how to run and develop the practice, and the GPs and management team encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

Are services well-led?

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 every three months for a formal meeting and were regularly invited to clinical and practice meetings where they were able to contribute to discussions about practice processes. They also met every Friday as part of a practice gardening group and for tea and coffee and informal discussions in the practice. The PPG carried out patient surveys and submitted proposals for improvements to the practice management team. For example, as a result of fundraising events held by the PPG, they purchased a defibrillator for the practice and requests from the PPG have led to the practice installing a dedicated PPG notice board and the PPG secretary producing a regular patient newsletter.
- the NHS Friends and Family test, complaints and compliments received.
- staff through away days and generally through staff meetings, appraisals and discussion. Staff told us they

would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example staff told us that they helped to design the appointment system and the process for handling patient referrals. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had a very good understanding of their performance and had taken steps to address all areas where they were underperforming and regularly reviewed this and discussed this with all members of staff and their PPG. There was a very active PPG which the practice supported and it played a big part in how the practice was run.