

Handsworth Medical Practice

Quality Report

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Date of inspection visit: 17 December 2015
Date of publication: 04/02/2016

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Handsworth Medical Practice on 17 December 2015. Overall the practice is rated as good.

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

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they found it easy to make an appointment and they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Information about services and how to complain was available and easy to understand.
- 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 areas where the provider should make improvement are:

- Ensure Control of Substances Hazardous to Health (COSHH) risk assessments are made available to all staff.
- Ensure audits have standards and where appropriate cycles are complete.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were clear safeguarding measures in place to help protect children and vulnerable adults from the risk of abuse.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were generally above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. NICE produce and issue clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to improve outcomes for patients.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect. Staff members we spoke with told us how they took steps to maintain patient confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found they were able to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day. Patients had the option to come into the surgery before 10am without an appointment, and as long as they were prepared to wait they would be seen by the GP. The practice building was purpose built and was well equipped to

Good



Summary of findings

treat patients and meet their needs. Staff members had completed training in equality and diversity and were sensitive to the needs of patients. Information about how to complain was available and easy to understand. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy and this was displayed in the reception area. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had an active patient participation group (PPG) and responded to feedback from patients about ways that improvements could be made to the services offered. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. For example, the practice's flu target for Over 65's was being well met. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia; end of life care and for unplanned admissions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The text size on the practice website could be adjusted for those with difficulties with their vision.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and the practice took part in the unplanned admissions enhanced service to identifying those with high needs and contacting them after hospital discharge to offer help and support. Longer appointments and home visits were available when needed. As there was one GP partner all patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Appointments were available outside of school hours and children were given appointments as a priority. The premises were accessible for parents with small children and babies using pushchairs. Sexual health advice and screening was available and patients were informed of this. We saw positive examples of joint working with midwives, health visitors and school nurses.

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 this patient population had been identified and the practice had

Good



Summary of findings

adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, late night appointments were available for working age patients until 6.30pm. The practice offered online services and telephone consultations as well as a full range of health promotion and screening that reflected the needs of this age group. They included NHS health checks for patients aged 40 to 74, cervical cytology for eligible women as well as tests to detect prostate cancer in men.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. We saw that there were 14 patients on the learning disability register and the practice had carried out annual health checks for most of those on the register. It offered longer appointments for people with a learning disability. The practice worked with multidisciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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). We saw that there were 37 patients on the mental health register and the practice had carried out annual physical health checks for most of those on the register with an agreed care plan. The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice carried out patient health questionnaires to monitor the severity of depression and response to treatment. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Information was made available at the practice to sign post patients to various support groups and services as well making referrals to healthy minds and the Community Psychiatric Nurse (CPN). It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published on 8 July 2015 showed the practice was generally performing in line with local averages. However, its performance was worse when compared to the national averages. Of the 455 survey forms were distributed, 80 were returned. This represented 18% of the practice's patient list.

- 71% found it easy to get through to this surgery by phone compared to a CCG average of 63% and a national average of 73%.
- 76% were able to get an appointment to see or speak to someone the last time they tried (CCG average 77%, national average 85%).
- 76% described the overall experience of their GP surgery as good (CCG average 77%, national average 85%).

- 59% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 65%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received eight comment cards which were all positive about the standard of care received. Patients commented that they were treated with care, dignity and respect.

We spoke with five patients during the inspection including a member of the PPG. All the patients said they were happy with the care they had received and were able to get an appointment when required. Patients' comments regarding the practice staff were positive.

Areas for improvement

Action the service **SHOULD** take to improve

The areas where the provider should make improvement are:

- Ensure COSHH risk assessments are made available to all staff.
- Ensure audits have standards and where appropriate cycles are complete

Handsworth Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Handsworth Medical Practice

Handsworth medical practice provides primary medical services to approximately 4000 patients in the local community. The practice was a partnership between the GP (male) and the practice manager. The GP is supported by a practice nurse and one health care assistant. The non-clinical team consists of reception staff and the practice manager.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care. The practice also provides some directed enhanced services such as minor surgery, childhood vaccination and immunisation schemes. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice opening times are 9am to 12pm Monday to Fridays and 4pm to 6pm Mondays, Tuesdays and Fridays. The practice is closed in the afternoons on Wednesdays and on Thursdays the practice is open from 5.30pm to 8.30pm.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by an external out-of-hours service provider when closed.

The practice had joined a GP partnership consisting of 32 practices. However, this still allowed the practice to retain their individual identity.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in an area of high deprivation score compared to other practices nationally. Data showed that the practice has a higher than average practice population aged between 20 and 35 years in comparison to other practices nationally. The practice also has a lower than the national average number of patients aged 55 years and over.

The practice achieved 100% points for the Quality and Outcomes Framework (QOF) for the financial year 2014-2015. This was above the national average of 94%. The QOF is a voluntary annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit 17 December 2015. During our visit we spoke with a range of staff including a Healthcare Assistant (HCA), two reception staff, a nurse, the GP provider and the practice manager. We spoke with five patients one of whom was part of the Patient Participation Group (PPG). We Reviewed comment eight comment cards where patients and members of the public shared their views and experiences of the service.

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

- Is it safe?
- Is it effective?
- Is it caring?

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. Staff members we spoke with were aware of reporting and escalating incidents. Staff members told us that incidents were reported to the practice manager who then completed the appropriate forms. They also populated the incident on an electronic system which was shared with the Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We saw that the practice had recorded four significant events over the last 12 months. One example of a significant event related to a needle stick injury to a staff member. We saw that this was recorded and learning discussed at staff meetings. Staff members we spoke with also confirmed this.

Overview of safety systems and processes

The practice had systems in place to keep patients safe and safeguarded from abuse. These included arrangements to safeguard children and vulnerable adults from abuse and reflected relevant legislation and local requirements. The practice had safeguarding policies that clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP provider was the lead for safeguarding and had received training appropriate to their role. All other staff had also received training relevant to their role and were aware of the lead. We were told about a recent safeguarding issue at the practice. The discussed how they had contacted the Multi-Agency Safeguarding Hub (MASH) for further advice. This demonstrated that staff understood their responsibilities in regards to safeguarding.

Notices in the waiting areas and in 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 check (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. Staff were further supported by a chaperone policy that was available in the practice both electronically and in a folder. Staff members we spoke with confirmed this.

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. We saw that the last annual infection control audit was undertaken in November 2015 and was carried out by the practice nurse. The overall score was 91% and issues identified were around the carpeting of some of the consultation rooms. The practice had applied for funding so that carpets could be changed to a more suitable alternative. Treatment rooms we looked had appropriate flooring that were fit for purpose. The practice had put one of the treatment rooms out of use pending remedial work to ensure it was fit for purpose. This was after the effects of invasive tree roots.

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling and storing). We saw that the practice had kept the nebuliser, defibrillator and emergency oxygen together at a fixed location so that all staff were aware. This was in response to an incident where a locum GP was unable to locate the nebuliser.

The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

We saw Patient Group Directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants (HCA) to administer vaccinations after specific training when a doctor or nurse was on the premises.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to

Are services safe?

employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme. The practice followed up all women who were referred as a result of abnormal results. We saw that the practice nurse was aware of their inadequate cervical cytology rate (0.9%) and recalled patients where necessary.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. There were fire evacuation procedures displayed in staff and patient areas of the building. Staff had received fire marshal training and there was a designated fire marshal. We saw evidence of regular emergency lighting test, fire drills and fire extinguisher checks that were being carried out.

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH). This included risk assessments for cleaning products used by the cleaner. However, this was not accessible by the cleaner.

The practice had undertaken a legionella test (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and were following actions identified.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Most staff worked set hours and a staff member we spoke with told us that they had capacity to work overtime. We saw that the healthcare assistant also worked in reception and told us that if there was a need they could cover in reception. The practice also had access to locum clinical staff if required.

Arrangements to deal with emergencies and major incidents

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

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. 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. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice manager told us that they had an arrangement to use the facilities of another surgery when required. However, this surgery was slightly further away and the practice manager told us that they had discussed arrangements with a nearby practice but were unable to reach an agreement.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards. This included the National Institute for Health and Care Excellence (NICE) best practice guidelines. The GP also told us how they attended GP update courses to keep up to date with current practice.

Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. We saw a folder in the staff area with current NICE guidelines for staff to access. Guidelines were discussed regularly but informally as there was a small clinical team.

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 100% of the total number of points available, with 5% exception reporting which was 4% below local and 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. Before our visit we saw that the practice was an outlier for the ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD). We spoke with the GP regarding this and we were told that this was to a large extent due to patient population who did not smoke. We were told that this had been looked into by the CCG. Data from 2014-2015 showed;

- Performance for diabetes related indicators was better compared to the CCG and national average. The practice achievement for the diabetes indicators was 100% which was 15% above the CCG and 11% above the national average. The exception reporting was lower than local and national averages for all domains.

- The percentage of patients with hypertension having regular blood pressure tests was better compared to the CCG and national average. The practice achievement was 91% which was 9% better than the local CCG and 8% above the national average.
- Performance for mental health related indicators was better than local and national averages at 100%. This was 11% above local and 7% above national averages.

We were shown some audits that the practice had conducted. This included information on diabetes, Chronic Kidney Disease (CKD), as well as others such as vaccine uptake for whooping cough and minor surgery. However most of these were data extractions rather than audits as standards were not set. Where standards for audits were set (such as for CKD and diabetes), no re-audits were conducted.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. There was an established team which included GP partner and the practice manager who was also a partner. The team also included a practice nurse and a healthcare assistant (HCA). The practice manager also carried out the role of a HCA when required. The non-clinical team consisted of administrative/reception staff and a practice manager. The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

The practice was proactive in providing training to staff. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included core training in areas such as safeguarding children and vulnerable adults, basic life support and infection prevention and control. Staff had received training and updates relevant to their role, for example the GP had received level three safeguarding training and had received an update on minor surgery. Staff discussed with us training opportunities they had been given to develop skills in line with their roles and responsibilities. For example, one of the staff members we spoke with told us that they received specific training for an extra role they wanted to undertake.

Are services effective?

(for example, treatment is effective)

The learning needs of staff were identified through a system of appraisals and meetings. We saw that a number of staff had received an appraisal within the last 12 months.

The GP partner had specialist interests and utilised their knowledge and skills in practice to improve outcomes for patients. For example, they were a former surgeon and as a result they undertook minor surgery in the practice. The GP told us that they were an Ear Nose and Throat (ENT) surgeon previously. As they still had an interest in this area, until recently hosted a two year pilot community ENT service to patients in collaboration with another GP provider. The GP had completed a diploma to refresh their knowledge in this area.

Regular staff meetings provided the opportunity to share important information with staff. The minutes showed that these meetings were detailed and covered a number of areas including significant events and complaints.

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, their intranet and an integrated pathology and discharge summaries system linked to the local acute hospital. This included care plans, risk assessments, medical records and results of tests and investigations. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

The practice referred patients appropriately to secondary and other community care services such as the district nurses. The practice used the Choose and Book system for making the majority of patient referrals. The Choose and Book system enables patients to choose at which hospital they would prefer to be seen.

Staff worked together and with other health and social care services 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. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Information on the Mental Capacity Act 2005 was available for staff. Our discussion with staff demonstrated that they understood the relevant consent and decision-making requirements of legislation when providing care and treatment and would act on any concerns about a person lacking capacity to consent. This included Gillick competence (the Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). Staff confirmed that assessments of capacity to consent would be carried out in line with relevant guidance.

The GP carried out minor surgery, a summary of minor surgery audit we looked at showed that the practice had carried out 34 procedures between 1 September 2014 and 31 December 2014. We saw that a consent form was available and had been used.

Supporting patients to live healthier lives

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

The practice had an electronic screen in the main reception area with health promotion information. There were also posters and practice leaflets with details of services for patients to access including a range of self-referral service such as sexual health, smoking cessation and mental health services.

The practice's uptake for the cervical screening programme was 83% over the last five years, which is better compared to the CCG average of 75% in 2011 and the national average of 79%.

There was a system in place to recall and follow up patients who did not attend for their cervical screening test. Findings were audited to ensure good practice was being followed.

The practice also undertook six to eight week development check for babies and mothers. Childhood immunisation rates for the vaccinations given were comparable to CCG/ national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 82% to 98% and five year olds from 81% to

Are services effective?

(for example, treatment is effective)

93%. Eligible children were identified and their parents/guardians were contacted to attend. Children attending schools were offered evening surgery appointments to better facilitate this. After the inspection the practice submitted the latest data on practice vaccination which showed that the rate for the practice had reached over 90% for both under two and five year olds.

Sexual health advice advice on safe sex and contraception was available. We saw posters on the notice boards in the reception area informing patients of this service.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that there was a queuing system in place in the reception area and a poster requesting patients to stay behind a line if someone else was at the reception desk.

All of the eight CQC comment cards we received were positive about the service experienced. Patients said staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We also spoke with five patients including a member of the Patient Participation Group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Results from the national GP patient survey published in January 2016 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice results for its satisfaction scores on consultations with doctors and nurses was mixed when compared to local and national average. For example:

- 79% said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 76% said the GP gave them enough time (CCG average 81%, national average 89%).
- 88% said they had confidence and trust in the last GP they saw (CCG average 92%, national average 95%)
- 81% said the last GP they spoke to was good at treating them with care and concern (CCG average 80%, national average 95%).

- 89% said the last nurse they spoke to was good at treating them with care and concern (CCG average 86%, national average 91%).
- 89% said they found the receptionists at the practice helpful (CCG average 81%, national average 87%)

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey was also mixed for the practice as ratings for the nurse was better than the GP compared to local and national averages. However, ratings for the GP were slightly lower but not significantly different from local and national averages. For example:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care (CCG average 76%, national average 82%)
- 91% said the last nurse they saw was good at involving them in decisions about their care (CCG average 86%, national average 90%)

Staff told us that translation services were available for patients who did not have English as a first language. However, a high proportion of patients registered with the practice were from a South Asian background and most of the staff including the GP and the healthcare assistant could communicate with most of these patients if they did not speak English.

Patient and carer support to cope emotionally with care and treatment

The practice screened patients with memory problems and referred them to appropriate services. Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Are services caring?

Patients were monitored for severity of depression and response to treatment through questionnaires and were referred to appropriate organisations such as health minds or the community psychiatric nurse (CPN).

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 80 carers of which 56 were registered with the practice as patients. This

represented a 1.4% of the practice list as carers or 2% with the total number of carers identified. Written information was available to direct carers to the various avenues of support available to them in the two reception areas.

Staff told us that if families had suffered bereavement the GP offered consultations and referred to other agencies such as Cruse bereavement care.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. For example, the practice provided minor surgical procedures to patients in the practice.

The practice worked with the CCG pharmacists to enable the practice to have safe and appropriate prescribing of medications and increase efficiency in repeat prescribing. The pharmacists also undertook audits with the practice to ensure prescribing was in line with best practice guidelines and to improve safety and effectiveness. For example, we saw evidence that the practice was below the CCG target for prescribing antibiotics.

There were extended opening hours on Thursdays when it was open from 5.30pm to 8.30pm and patients could book appointments and order repeat prescriptions on line which would benefit patients unable to visit the practice during the main part of the day. For example, patients who worked during these hours.

Urgent access appointments were available on the same day for children, the elderly and patients who were vulnerable. If there were no appointments available patients were given the option to see the GP as long as they arrived into the surgery before 10am and were prepared to wait.

Systems to review and recall patients with long term conditions such as asthma, diabetes and chronic obstructive pulmonary disease (COPD) were in place. COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.

The practice had a Patient Participation Group (PPG). We spoke with a member during the inspection. PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. There was evidence from minutes of meetings and discussion with the PPG member that the practice engaged with patients and took on feedback. The PPG helped to carry out the patient

survey and the analysis of results for 2014 was available for patients in the reception area. Action taken as a result of patient feedback included the option for patients to have their blood taken at the practice once a week instead of attending the hospital. This was confirmed by the PPG member we spoke with.

The practice had ramped access for patients using a wheel chair. The practice had recognised the need to have an automated front door in a Disability Discrimination Act (DDA) audit and had applied for extra funding. The reception desk had a disabled counter which could be used by patients using a wheel chair. Staff were sensitive to the needs of the diverse community of patients and had completed training in equality and diversity. The DDA act has been repealed and replaced by the Equality Act 2010.

The text size on the practice website could be adjusted for those with difficulties with their vision.

Access to the service

The practice was open between 9am and 6pm daily except on Wednesdays when it closed at 12pm. Appointments were from 9am to 11am every morning and 4pm to 5.30pm daily. Extended surgery hours were offered on Thursdays until 8.30pm. When the surgery was closed, the service was provided by an out-of-hours provider.

There was one GP who was supported by a part time practice nurse to meet the needs of approximately 4000 patients. The partners told us that they had reached maximum capacity in regards to patient population and currently were not taking on new patients unless they were family members of existing patients. We saw some negative feedback from patients on the NHS choices website regarding access to appointments. However, the patients we spoke with were positive about the access to appointments and the comments cards also aligned to the views of the patients we spoke with. The staff we spoke with explained that when there were no appointments available patients were offered the option to attend the surgery before 10am. As long as they did not mind waiting they would be guaranteed to see the GP.

Although the results from the national GP patient survey showed that overall patient's satisfaction with how they could access care and treatment was slightly lower compared to local and national averages. They were not significantly different.

Are services responsive to people's needs?

(for example, to feedback?)

- 68% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 83% patients said they could get through easily to the surgery by phone (CCG average 62%, national average 73%).
- 53% patients said they always or almost always see or speak to the GP they prefer (CCG average 47%, national average 59%).

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system which included a poster a complaints policy and practice leaflet. Patients we spoke with said that they had not needed to make a complaint but told us that would speak with a member of staff if they wished to do so. Staff members we spoke with were aware of the complaints process and described what they would do if a patient wanted to complain. We saw that the practice had received two complaints from December 2014 to December 2015. We saw that complaints were responded to appropriately and learnings were discussed in team meetings.

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 with compassion. Its value was to treat patients with respect and dignity and promote independence in their health and wellbeing. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.

The practice had joined a GP partnership consisting of 32 practices. However, this still allowed the practice to retain their individual identity. The GP provider told us that they felt this would allow the practice to access more clinical and administration staff to offer a better service to their patients.

Governance arrangements

The practice had a governance framework in place that supported the delivery of the strategy and deliver quality care. The practice manager worked as a healthcare assistant and at reception when needed.

There was a clear staffing structure and staff were aware of their own roles and responsibilities. All staff were trained as fire marshals but a designated chair in the reception meant that the staff member using this chair also had the responsibility to act as the fire marshal for the day.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a national performance measurement tool. The QOF data for this practice showed that in all relevant services it was performing above or in line with national standards. We saw that QOF data was regularly discussed at meetings and action taken to maintain or improve outcomes.

The practice showed us many audits that they were conducting. However, most did not have any standards and the majority were data extracts from the QOF targets. Although they were not audits they still allowed the practice to monitor its performance in regards to QOF and other outcomes.

Leadership and culture

The partners consisted of the GP and the practice manager. The practice manager also worked in the reception and as

a HCA when required. The practice staff team was small and the GP and the practice manager were visible in the practice. Staff told us that they were approachable and always took the time to listen to all members of staff.

Staff told us and records we looked at showed that regular team meetings were held. Staff also told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Staff said they were confident in raising any issues and felt supported if they did so. For example, one staff member we spoke with told us that one of their roles was to undertake scanning of documents onto the computer system alongside their duties in reception. However, they had fed back that due to volume of documents they needed to scan they found it difficult whilst also fulfilling their duty in reception. As a response they were set aside protected time and did not have to undertake their role at reception.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, we spoke with a member of the PPG group who told us that there were 18 members in the group and that they usually met between two and three months, and during the last meeting 12 people had attended. We were told that the practice telephone number had been changed from a premium rate number to a local rate number. The practice had installed an electronic screen and the PPG member told us that they had requested this and had written to the CCG for funding support.

We saw that the practice had undertaken a survey through the PPG in 2014 and the analysis and actions plan were displayed in the reception area for patients. The practice had also carried out another survey for 2015 and was currently being analysed.

Continuous improvement

Are services well-led?

Good 

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

There was a strong focus on continuous learning and improvement through data extraction and audits. Although many of the audits needed to have standards set and re-audited to show improvement, we saw that there were many areas that were being monitored as a result.

The GP had an interest in the area of Ear, Nose and Throat (ENT) medicine as they were a former ENT surgeon. Until

recently the practice had hosted a two year pilot community ENT service to patients in collaboration with another GP provider. This service was delivered by the GP along with other relevant professionals and the GP had completed a diploma to refresh their knowledge in this area.