Belvedere Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Belvedere Medical Centre on 17 September 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Most risks to patients were assessed and well managed, apart from those relating to medical emergencies and Legionella.

We saw some areas of outstanding practice:

- The practice had developed an innovative staffing model for providing patient care. The practice had a very good skill mix, which included advanced nurse practitioners (ANPs), a 'non-medical prescriber' practice nurse, a pharmacist and a primary care assistant practitioner (PCAP). They were all able to see a broad range of patients so that the clinical workload was successfully shared across the team. The feedback from patients indicated a high level of satisfaction with this model of care; patients had good access to the practitioner of their choice.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. Staff were empowered to make suggestions and implement changes to improve the quality of the service. For example, one of the practice nurses had identified chlamydia testing as an area for improvement and taken successful actions leading to improved detection rates. This had led to an improved rate of chlamydia testing and one of the highest levels of chlamydia detection rates for the practice population as evidenced by recent figures provided by clinical commissioning group (CCG).

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Ensure that actions resulting from the Legionella risk assessment are implemented, so risks are managed appropriately.
- Continue to review arrangements for responding to medical emergencies to ensure that the equipment is immediately available for use, staff are aware of its location and are trained to use it.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Most risks to patients were assessed and well managed, apart from those relating to medical emergencies and Legionella. The practice had not acted on all of the recommendations following a Legionella risk assessment, carried out in 2014, to minimise the risks identified. We also found that the practice did not have some emergency equipment, such as oxygen and a defibrillator, on the day of the inspection. The practice had considered the location of a nearby ambulance station sufficient to meet the need for responding to emergencies. However, we disagreed with this conclusion. The was quick to respond in relation to feedback about these issues. For example, the practice sent us evidence the day after the inspection to show that both items of emergency equipment had been ordered for the immediate use at the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Clinical audits were used effectively to drive improvements in care.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice had care plans in place for a range of at risk groups, including, for example, those diagnosed with dementia or nearing the end of their lives. The practice promoted screening uptake for relevant cancers and could demonstrate high-levels of ad hoc chlamydia testing and detection.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Data showed that patients rated the practice similar to others for several aspects of care. The majority of patients said they were treated with compassion, dignity and respect. However, some feedback from patients indicated that they did not always feel cared for and listened to. The practice had identified this issue through its own patient satisfaction survey and clinicians were working towards addressing the issue, for example, by attending training courses in communication skills.

One of the nurse practitioners worked closely with patients nearing the end of their lives; they liaised with palliative care services in the local area and worked with patients to identify their needs. The practice had recently been commended by the local Clinical Commissioning Group (CCG) for enabling patients to die at their preferred place of care and in line with their advanced care plan.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as outstanding for being well-led. It had a clear vision and strategy which had been regularly reviewed and discussed with staff and representatives from the Patient Participation Group (PPG). High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and actions were taken to improve performance where ever possible. Staff were empowered to identify and act on areas where they felt the quality of service could be improved.

Summary of findings

We observed a range of instances which demonstrated how the cohesive governance and staffing strategies had led to improved outcomes for patients. These included actions to improve access through the monitoring of the available mix of skills among staff and the appointments system, identification of opportunities to promote good health and prevent disease, and co-ordination of patient care with other providers.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice performed above average in its provision of care for patients nearing the end of their lives. The practice had recently been commended by the local Clinical Commissioning Group (CCG) for enabling patients to die at their preferred place of care and in line with their advanced care plan.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients 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 named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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 accident and emergency (A&E) attendances. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Immunisation rates were in line with averages for all standard childhood immunisations. Staff had implemented several strategies for improving rates of immunisation including the provision of written information about the risks and benefits as well as personal phone calls to discuss uptake issues with parents.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered early appointments from 7.00am Monday to Friday to support patients to access care outside of normal working hours. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Ninety seven per cent of people experiencing poor mental health and 100% of people diagnosed with dementia had a care plan in place. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It had proactively audited patient records to identify those at risk of developing dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above or in line with local and national averages. There were 111 responses representing a response rate of 28%.

- 96% find it easy to get through to this surgery by phone compared with a Clinical Commissioning Group (CCG) average of 61% and a national average of 74%.
- 92% find the receptionists at this surgery helpful compared with a CCG average of 81% and a national average of 87%.
- 60% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 54% and a national average of 61%.
- 88% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 79% and a national average of 85%.
- 97% say the last appointment they got was convenient compared with a CCG average of 89% and a national average of 92%.
- 86% describe their experience of making an appointment as good compared with a CCG average of 64% and a national average of 74%.
- 46% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 57% and a national average of 65%.
- 73% feel they don't normally have to wait too long to be seen compared with a CCG average of 51% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards; the majority of these were positive about the standard of care received. We also spoke with 13 patients on the day of the inspection and met with three members of the Patient Participation Group. The majority of the information received from these sources was also complimentary. People told us that they felt well-cared for and particularly praised the nursing staff in terms of their listening and support skills. They also said they had good access to appointments with all of the clinicians. People especially liked the walk-in service which meant they were seen on the same day rather than booking appointments in advance.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that actions resulting from the Legionella risk assessment are implemented, so risks are managed appropriately.
- Continue to review arrangements for responding to medical emergencies to ensure that the equipment is immediately available for use, staff are aware of its location and are trained to use it.

Outstanding practice

- The practice had developed an innovative staffing model for providing patient care. The practice had a very good skill mix, which included advanced nurse practitioners (ANPs), a 'non-medical prescriber' practice nurse, a pharmacist and a primary care assistant practitioner (PCAP). They were all able to see a broad range of patients so that the clinical workload was successfully shared across the team. The feedback from patients indicated a high level of satisfaction with this model of care; patients had good access to the practitioner of their choice.
- There was a clear leadership structure and staff felt supported by management. Staff were empowered to make suggestions and implement changes to improve the quality of the service. For example, one of the practice nurses had identified chlamydia testing as an area for improvement and taken successful actions

leading to improved detection rates. This had led to an improved rate of chlamydia testing and one of the highest levels of chlamydia detection rates for practice population, as evidenced by recent figures provided by the clinical commissioning group (CCG).

Belvedere Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an Expert by Experience. They were granted the same authority to enter the practice premises as the CQC inspectors.

Background to Belvedere Medical Centre

The Belvedere Medical Centre is located in Belvedere in the London Borough of Bexley. The practice serves approximately 8500 people living in the local area. The local area is diverse. People living in the area spoke a range of different languages and expressed different cultural needs.

The practice operates from a single site. It is situated in two-storey purpose-built premises with a range of consulting rooms on both floors. It is fully wheelchair accessible with disabled parking, level access, wide corridors and lift to the top floor.

There is a lead GP (male) and a salaried GP (female) working at the practice. There is also a practice manager, two advanced nurse practitioners, two practice nurses, an assistant primary care practitioner and a pharmacist advisor, as well as reception and administrative staff.

The practice offers appointments on the day and books appointments up to two weeks in advance. The practice has appointments 7.00am to 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays. They are open on Thursdays from 7.00am to 1.00pm. The GPs remain on-call for urgent appointments up to 6.30pm Monday to Friday. Patients who need attention outside of these times are directed to call the 111 service for advice and onward referral to other GP out-of-hours services.

The Belvedere Medical Centre is contracted by NHS England to provide Personal Medical Services (PMS). They are registered with the Care Quality Commission (CQC) to carry out the following regulated activities: Family planning; Diagnostic and screening procedures; Treatment of disease, disorder or injury; Maternity and midwifery services.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

How we carried out this inspection

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

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

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice. We carried out an announced visit on 17 September 2015. During our visit we spoke with a range of staff. We spoke with the lead GP, the salaried GP and a locum GP, a nurse practitioner, a practice nurse, the practice manager, an office manager and two receptionists. We spoke with 13 patients who used the service and reviewed CQC comment cards completed by 37 patients. We conducted a tour of the surgery and looked at the storage of medicines and equipment. We reviewed relevant documents produced by the practice which related to patient safety and quality monitoring. We checked some patients' care plans and associated notes.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. It was the practice's policy to offer people affected by significant events a timely and sincere apology and people were told about actions taken to improve care.

Staff told us they would inform the practice manager of any incidents. There was a recording form available on the practice's computer system and a copy could also be requested from the practice manager.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. All complaints received by the practice were also recorded and discussed at the clinical meetings to identify any safety issues which needed to be addressed. Three significant events had been recorded in the past year and 10 complaints had been received. We checked documents related to these events. Lessons were shared to make sure action was taken to improve safety in the practice. For example, one of the incidents related to the issuing of repeat prescriptions. The practice had responded immediately by raising an alert with the local Clinical Commissioning Group (CCG). This had led to a change in practice policy to ensure that the problem did not recur. The new policy had been discussed and shared at a staff meeting. The staff we spoke to recalled the incident and the discussions held at the meeting regarding the change in policy.

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

Overview of safety systems and processes

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

- Arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Safeguarding policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. We noted that monthly meetings were held with health visitors to discuss children who may be at risk. The practice also monitored and followed up children who failed to attend for appointments in primary or secondary care. Patients who had been identified as being at risk were flagged on the computer system so that all staff were aware of the issues and could respond sensitively during a consultation. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice displayed in the waiting room, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring service check (DBS). (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 maintenance and monitoring of appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the nurse practitioners was the infection control clinical lead who liaised with the local infection prevention team to keep up to date with best practice. There was an infection control protocol in place and staff were following this. The majority of staff had received up-to-date training and the practice manager could show that staff in need of an update had been booked on a relevant course. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- Arrangements for the safe management of medicines, such as emergency drugs and vaccines (including obtaining, prescribing, recording, handling, storing and security). Regular medicines audits were carried out with the support of the local Clinical Commissioning Group (CCG) pharmacy teams to ensure the practice was prescribing safely, in line with current guidelines. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks to ensure that staff had the proper skills and experience to carry out the role. We reviewed six files which showed that appropriate recruitment checks had been undertaken prior to employment. For

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

- Arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an agreed system in place for all the different staffing groups to ensure that enough staff were on duty, for example, there was a limit to the number of staff who could take annual leave at the same time.
- Procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up-to-date fire risk assessments and regular fire drills were 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) and infection control. However, we noted that although the practice had invited an external contractor to assess and advise on the risk of Legionella at the practice in 2014, not all of the actions suggested by the contractor had been followed up. For example, the practice had set the water cylinder to the correct temperature following advice, but had not regularly tested and recorded the water temperature in line with the advice received.

Arrangements to deal with emergencies and major incidents

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.

There were panic buttons available on the ground floor of the premises to alert members of staff to an emergency. The first floor of the premises were part of a redevelopment plan which would include the installation of panic buttons on this floor.

All staff received annual basic life support training and there were emergency medicines available in one of the treatment rooms. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice did not have oxygen or a defibrillator on the day of the inspection. We discussed this issue with the lead GP who told us they had considered the risks to be low because of the co-location of an ambulance station nearby. However, we disagreed with this conclusion and discussed the Resuscitation Council UK guidelines for primary care in relation to the need for this equipment to be available immediately in the event of an emergency. Therefore, the lead GP reconsidered their assessment of risk and sent us confirmation the day after the inspection that both an oxygen cylinder and defibrillator had been ordered for the immediate use at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) guidelines. The practice had systems in place to ensure all clinical staff were kept up to date.

The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. For example, we noted that the lead GP had recently disseminated new guidance around both the early diagnosis of cancer and atrial fibrillation assessment. The practice monitored that these guidelines were followed through by holding discussions at clinical meetings, carrying out risk assessments and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice.) The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. One of the nurse practitioners took the lead in monitoring QOF performance. They had developed good working relationships with many of the patients affected by long-term conditions and this meant that exception reporting was in line with the national average (i.e. 4%). Therefore the practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013/14 showed that the practice achieved 98.4% of the total number of points available. Results showed that:

- Performance for diabetes-related indicators was similar to the national average. For example, 92% of patients with diabetes had had a foot exam in the past 12 months compared to a national average of 88%.
- The percentage of patients with hypertension having regular blood pressure tests was 86% which was similar to the national average of 83%.
- Performance for mental health related indicators was generally better than the national average. For example, 97% of patients with a diagnosed mental health disorder had a care plan in place, compared to a national average of 86%.
- The practice also performed better than average in its care for patients with dementia. They had proactively monitored rates of dementia diagnosis by carrying out a search of practice records in June 2015. This had successfully identified additional patients in need of onward referral to a memory clinic. 100% of patients diagnosed with dementia had a care plan in place compared to a national average of 83%

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and patients' outcomes. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. There had been a wide range of clinical audits completed in the last three years. We looked at three of these and found that the results were used to improve services. For example, in 2012 the practice had initiated a review of its prescribing practices for medicines aimed at lowering blood pressure and cholesterol in response to advice from the Medicines and Healthcare products Regulatory Agency (MHRA). The prescribing issues were discussed at a clinical meeting and actions agreed upon. A follow up audit in 2013 demonstrated that patients affected by the new prescribing advice had been successfully moved on to a more appropriate medication regime.

Effective staffing

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

- The practice had an induction programme for newly appointed members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

We noted that the practice staffing was diverse in terms of skill mix; there were advanced nurse practitioners, a pharmacist advisor, a primary care assistant practitioner and practice nurses with qualifications in non-medical prescribing. Many of the staff members had worked at the practice for a long period of time and been encouraged to gain additional qualifications, with associated role promotions, during their period of employment. The lead GP told us that this was part of an ongoing commitment to develop staff at the practice so that they could be confident that all staff continued to improve their skills and were offering a high quality of care to their patients.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. For example, all test results and letters from secondary care were added to the computer record on the same day that they were received so that clinicians could respond promptly to the new information. Information, such as NHS patient information leaflets, were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services

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 people moved between services, such as when they were referred, or after they were discharged from hospital. We noted that some of the complaints received by the practice in the past 12 months had related to referrals. However, we found that these related to the co-ordination of care and timely provision of appointments by the secondary care services. The practice had followed up any issues on their patients' behalf in order to support them to gain access to the relevant services.

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 always sought 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and family planning. Patients were then signposted to the relevant service. For example, the practice had recently identified children who were at risk of becoming overweight or obese and invited them to attend for an appointment where lifestyle advice and onward referral to support services were discussed.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. One of the practice nurses had also promoted the use of opportunistic chlamydia testing and had organised an educational event for the staff at the practice. This had led to an improved rate of chlamydia testing and one of the highest levels of chlamydia detection rates for practice population, as evidenced by recent figures provided by clinical commissioning group (CCG).

Flu vaccination rates for the over 65s were 78%, and at risk groups 59%. These were above the CCG and national averages. Childhood immunisation rates for the

Good

Are services effective?

(for example, treatment is effective)

vaccinations given were comparable to CCG averages. The practice had worked towards improving vaccination rates through the provision of written information to address parental concerns and personal phone calls with parents to discuss vaccination uptake.

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 years. Appropriate follow-ups on the outcomes of health assessments and checks were made where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

The majority of the 37 patient CQC comment cards we received were positive about the service experienced. We also spoke with 13 patients on the day of the inspection; the majority of these patients were also positive about the experience of visiting the practice. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with three members of the Patient Participation Group (PPG) on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Comment cards and interviews with patients highlighted that staff responded compassionately when they needed help and provided support when required. However, there was some, limited negative feedback related to the consultation style of some clinicians.

Results from the national GP patient survey showed that the majority of patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice had largely comparable satisfaction scores on consultations with doctors and nurses. For example:

- 86% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 86% and national average of 89%.
- 79% said the GP gave them enough time compared to the CCG average of 83% and national average of 87%.
- 92% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and national average of 87%.

There was one area where the survey highlighted lower than average scores which was in line with some of the feedback we had received via the comments cards and patient interviews:

- 72% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 80% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.

We noted that the clinicians involved had already acted on feedback obtained via the practice's own satisfaction survey to improve their communication skills, for example, through the provision of additional training in this area.

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. The majority 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 mainly positive and aligned with these views.

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

- 89% said the last nurse they saw was good at explaining tests and treatments which was in line with the Clinical Commissioning Group (CCG) average of 87%, and the national average of 90%

However, the results for satisfaction with GPs were less positive, but the practice were aware of this and were working to address the concerns:

Good

Are services caring?

- 77% said the last GP they saw was good at explaining tests and treatments which was below the CCG average of 83%, and the national average of 86%.
- 71% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 81%.

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

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and they were being supported, for example, by being offered health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered 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.

One of the nurse practitioners was the named lead clinician for end-of-life care. They had worked closely with other services to provide co-ordinated care for people reaching the end of their lives. The practice had recently been commended by the Clinical Commissioning Group (CCG) for enabling patients to die at their preferred place of care and in line with their advanced care plan.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. The lead GP was a board member of the CCG and was therefore regularly engaged in the setting of targets and priorities in relation to local health needs. The CCG priorities were noted and acted on by the practice. For example, one of the nurse practitioners was taking the lead in implementing a health check for seven year olds following the setting of a childhood obesity target by the CCG.

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

- The practice offered early opening hours, from 7.00am every day of the working week to enable working age patients to access timely medical care outside of normal opening hours.
- There were longer appointments available for people with a learning disability or other complex needs.
- The practice had a clear policy for supporting patients living in vulnerable circumstances including homeless people, travellers and asylum seekers. They were all enabled to register at the practice in order to be seen promptly by a clinician.
- Patients could choose to see a clinician of their choice and could specify if they wished to see a male or female clinician.
- Home visits were available for older patients or other patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, a hearing loop and translation services available.
- All clinical rooms had wide door frames with space for wheelchairs and prams or pushchairs to manoeuvre.
- The development plans for the premises gave due consideration to those with mobility issues. For example, there were plans for installing a lowered reception desk for people using wheelchairs.

Access to the service

The practice was open between 7.00am and 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays. They were also open on Thursdays from 7.00am to 1.00pm. Extended hours surgeries were offered on weekdays between 7.00am and 8.30am. Patients were invited to the walk-in service for appointments every week day morning and on Friday afternoons. Pre-bookable appointments in the afternoons could be booked up to two weeks in advance. Urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was above local and national averages. The people we spoke to on the day, and the feedback from comment cards, showed that patients were able to get appointments when they needed them. Many patients particularly praised they system in terms of being able to see a clinician of their choice in good time. For example:

- 86% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 70% and national average of 76%.
- 96% patients said they could get through easily to the surgery by phone compared to the CCG average of 61% and national average of 74%.
- 86% patients described their experience of making an appointment as good compared to the CCG average of 64% and national average of 74%.
- 73% feel they don't normally have to wait too long to be seen compared with a CCG average of 51% and a national average of 58%.

The GP patient survey highlighted one aspect where the practice performed less well:

- 46% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 57% and a national average of 65%.

The lead GP showed us how they audited and monitored waiting times at the walk-in and pre-booked clinics. The average waiting time was around 17 minutes. The practice continued to adjust the timings of their clinics to maximise the level of service. For example, we saw minutes from a nurses meeting where the provision of walk-in versus pre-booked appointments had been discussed. This had led to a change in practice which would then be reviewed again in three months' time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. For example, a poster was displayed in the waiting area and there was also a practice leaflet available which described how to make a complaint. Information about how to make a complaint was also displayed on the practice's website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at 10 complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way. The practice had operated in an open and transparent manner when dealing with the complaint. It was practice policy to offer an apology where they identified that things had gone wrong. We saw written examples of apologies that had been offered.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a complaint regarding confidentiality led to a review meeting with staff of the practice's confidentiality policy, in order to remind all staff about the importance of implementing strategies for maintaining patients' privacy and confidentiality.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high-quality care and promote good outcomes for patients. The practice had a mission statement which was displayed in the waiting area and there was a supporting statement on the website. The lead GP placed an emphasis on staff development and training as a method for providing a comprehensive and up-to-date, modern service. Staff shared and understood the lead GPs values; they worked together well and were committed to providing high-quality care in an open and learning environment.

The practice had a robust development strategy with supporting business plans. The practice list size was expanding at the time of the inspection. This reflected the success of the business in terms of providing high-quality care. There were now plans in place to develop the premises and recruit new staff in order to continue to meet the levels of patient demand. The lead GP was also in the process of seeking approval for the practice to become a vocational training practice for new GPs.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice-specific policies were implemented and were available to all staff.
- Staff shared a comprehensive understanding of the performance of the practice.
- There was a programme of continuous clinical and internal audit to monitor quality and to make improvements.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, the practice had not accurately considered the risks in response to medical emergencies, although this was immediately rectified following our inspection.

We noted several examples where the auditing system, and sharing of data regarding performance, had led to an improved quality of service. This included identifying areas of poor performance in the Quality Outcomes Framework and responses to the patient satisfaction survey. Strategies about how to improve had been discussed at staff meetings and the actions agreed were then implemented. For example, the careful monitoring of waiting times had led to several changes to the appointments system which had resulted in improved access and satisfaction amongst patients.

Leadership, openness and transparency

The lead GP and practice manager had the experience, capacity and capability to run the practice and ensure high-quality care. They prioritised safe, high quality and compassionate care. The lead GP and practice manager were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. They encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held and we reviewed minutes from these meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and in an ad hoc manner on a daily basis; they were confident in doing so and felt supported if they did. We also noted that team away days were held periodically, and at least once a year. Staff said they felt respected, valued and supported, by the lead GP and practice manager.

All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service. For example, one of the practice nurses identified and promoted the use of a scheme where free contraception was offered for chlamydia prevention. They arranged for the sponsor of the scheme to present relevant information to the staff at the practice. This had a direct impact on staff awareness regarding chlamydia prevention and testing. The practice had achieved one of the highest levels of chlamydia detection rates for practice population, as evidenced by recent figures provided by clinical commissioning group (CCG).

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the Patient Participation Group (PPG) and through surveys

Are services well-led?

Good

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

and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the results from a patient satisfaction survey carried out in November 2014 were subsequently discussed at a PPG meeting and an action plan was drawn up. Some of the issues related to the provision of information regarding staff roles, such as the difference between the nurse practitioner and practice nurse. We noted that the action plan had been followed up with information on staff roles now clearly displayed in the waiting area.

The practice had also gathered feedback from staff through staff away days, at staff meetings, staff appraisals and general daily discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff were empowered to take the lead in different areas and to make decisions about how the service could be improved. For example, the nursing team were in charge of monitoring and auditing their own clinic appointments system and were in the process of trying out different systems to improve patient access.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice had made a clear commitment to developing staff. The lead GP encouraged staff to increase their skills through obtaining additional qualifications. Therefore, the practice had a very good skill mix which included advanced nurse practitioners (ANPs), a 'non-medical prescriber' practice nurse, a pharmacist advisor and a primary care assistant practitioner (PCAP). They were all able to see a broad range of patients, as well as taking the lead for specific long-term conditions, so that the clinical workload was successfully shared across the team. For example, we noted that the nurse practitioner in charge of end-of-life care had spent time working with patients to draw up advanced care plans which identified their preferred place of care. They had worked with the local palliative care team to ensure that these wishes were followed as far as possible.

We saw instances when the range and depth of knowledge in the team had been put to good use. For example, the pharmacy advisor reviewed information received from secondary services regarding new medications and prescriptions for patients who had been discharged back to primary care. In some cases the pharmacist had raised prescribing queries with consultants in order to ensure the best quality of care for the patient.