Scarsdale Medical Centre

Quality Report

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Date of inspection visit: 23 September 2015
Date of publication: 03/12/2015

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 a comprehensive inspection of Scarsdale Medical Centre on 23 September 2015. Overall the practice is rated as good.

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

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

- Arrangements were in place to ensure patients were kept safe. For example, staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.
- Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and best practice guidance.
- We saw from our observations and heard from patients that they were treated with dignity and respect and all practice staff were compassionate.
- The practice understood the needs of their patients and was responsive to them. There was evidence of continuity of care and people were able to get urgent appointments on the same day.
- There was a culture of learning and staff felt supported and could give feedback and discuss any concerns or issues with colleagues and management.

However, there were also areas of practice where the provider should make improvements:

- The practice should ensure an automated external defibrillator (used to attempt to restart a person's heart in an emergency) is available or should carry out a risk assessment to identify what action would be taken in an emergency.

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. Risks to patients were assessed and well managed.

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. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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, and maintained confidentiality.

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able 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.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. 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 governance 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. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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.

Patients over 75 years had a named GP to co-ordinate their care. The practice was part of the whole systems integrated care (WSIC) pilot and held WSIC meetings for over 75s which were attended by GPs, district nurses and social services care coordinators. They had a list of older people who were housebound, whom they would visit regularly, particularly frail older patients. A Primary Care Navigator was based at the practice day a week, to support older patients and their carers to access timely care and community support. Their role included befriending, attending patients' homes, liaising with social services and acting as advocates. GPs told us they have reduced unnecessary hospital admissions, GP appointments and residential placements through timely intervention and care co-ordination.

People with long term conditions

Good

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

The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. The practice held registers for patients in receipt of palliative care, who had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs.

Patients in these groups had a care plan and would be allocated longer appointment times when needed. They are reviewed every six months and we saw where results were outside the normal range appropriate action was taken. They were then monitored closely before patients were returned to normal review periods. Services such as spirometry, smoking cessation, phlebotomy, ECG and anticoagulation monitoring are also provided by the practice.

Families, children and young people

Good

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

The practice took part in a mother and baby monthly Paediatric Hub Clinic in partnership with other GP practices and consultant paediatricians from the local hospital. We were told that the clinic had proved successful in reducing the number of referrals to

Summary of findings

secondary care and had allowed patients to see a consultant quickly within the community. The practice ran a weekly mother and baby and baby immunisation clinic which provided an opportunity for mothers to express any concerns to the GP or nurse that they may have. The nurse told us they liaise regularly with health visitors who also attend some Multi-Disciplinary Team Meetings. The practice offered appointments on the day for all children under five when their parent requests the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they promoted sexual health screening.

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 practice ran evening clinics twice a week which they told us was particularly popular with their working age patients. They also offered extended appointments, on-line booking of appointments, online ordering of repeat prescriptions and telephone consultations to speak with the GP or nurse in relation to test results.

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 GPs told us that patients whose circumstances may make them vulnerable such as the homeless, those under safeguarding or people with learning disabilities were offered regular health checks and follow-up. They said they would also refer them to other agencies including Improving Access to Psychological Therapies (IAPT, Mind, and Carers Groups). Any patients who were deemed vulnerable were discussed at the weekly clinical meeting by the relevant clinician. The practice also looked after a local homeless hostel and saw these patients regularly to enable early identification of physical health deterioration and prevent onward referral to secondary care.

People experiencing poor mental health (including people with dementia)

Good

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

The GPs told us that patients with poor mental health were looked after holistically at the practice as they had input from the community mental health teams (CMHT). They also had a counsellor based at the practice one day a week. They also had access to a primary care liaison nurse whose role was to support patients with

mental illness transition from secondary care to primary care to ensure a safe discharge process. They would also see patients referred to them from the practice. We saw the liaison nurse would refer patients to Improving Access to Psychological Therapies (IAPT), support patients themselves or refer directly to the acute brief assessment team in the local hospital.

Where appropriate, longer appointments were offered.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection and received 29 completed Care Quality Commission (CQC) patient feedback cards. We looked at the completed CQC comment feedback cards and all were positive about the practice.

All the patients we spoke with during the inspection told us they were satisfied with the overall quality of care and support offered by the practice from both clinical and non-clinical staff. Patients said the care was good and staff were friendly, professional and accommodating and that all staff treated them with dignity and respect. Most of the patients we spoke with had been registered with the practice for many years and told us staff were patient and understanding and the GPs gave consistently good care

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 90 responses and a response rate of 20%

- 86% find it easy to get through to this surgery by phone compared with a CCG average of 85% and a national average of 73%.
- 86% find the receptionists at this surgery helpful compared with a CCG average of 86% and a national average of 87%.
- 52% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 65% and a national average of 60%.
- 88% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.
- 96% say the last appointment they got was convenient compared with a CCG average of 91% and a national average of 92%.
- 83% describe their experience of making an appointment as good compared with a CCG average of 79% and a national average of 73%.
- 76% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 65% and a national average of 65%.
- 66% feel they don't normally have to wait too long to be seen compared with a CCG average of 58% and a national average of 58%.

Scarsdale 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, a practice nurse and an expert by experience.

Background to Scarsdale Medical Centre

Scarsdale Medical centre provides GP primary care services to approximately 6,500 people living in Kensington and Chelsea. The practice is staffed by six GPs, two male and four female who work a combination of full and part time hours. The practice is a training practice and employs two GP's in training, one nurse, three health care assistants, a practice manager and six administrative staff. The practice holds a Personal Medical Services (PMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice is open between 8am to 6.00pm Monday, Thursday and Fridays and 8am to 8.30pm on Tuesday and Wednesday. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

The practice provides a wide range of services including clinics for diabetes, chronic obstructive pulmonary disease (COPD), coil fitting and child health care. The practice also provides health promotion services including a flu vaccination programme, travel vaccinations and cervical screening.

The practice is located in an area where the population age group are mixed and ethnically diverse.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

We 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
- Mothers, babies, children and young people
- The working-age population and those recently retired

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 23 September 2015. During our visit we spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

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. Administrative staff told us they would inform the practice manager and send an email regarding any significant event or incident that takes place. These were usually discussed on the day they occurred and always discussed at the weekly management meeting.

The practice carried out an analysis of the significant events (SEA) quarterly which included identifying any themes and learning points.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw that where a delay had occurred in relation to two week referrals the practice immediately implemented a double checking process. The practice manager was sent details of all two week referrals so they could monitor and chase if necessary and patients were also asked to contact the practice if they had not hear from the hospital within the time frame.

National patient safety alerts were disseminated by the practice manager to the relevant practice staff by email through the practices computer system messaging facility. Staff we spoke with told us of recent alerts they had discussed regarding a diabetic drug.

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 were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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 were safeguarding folders in each treatment room where contact information was immediately accessible. There was a lead member of staff for safeguarding. The lead GP attended quarterly safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients they could ask for chaperones, if required. All staff who acted as chaperones were trained for the role. However, the administration staff who acted as chaperones on occasions had not been disclosure and barring checked (DBS) as they would never be left alone with a patient. (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).
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice also had a health and safety policy which staff were required to read as part of their induction which was accessible on all computer desktops. The practice had up to date fire risk assessments and 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 also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All equipment was PAT tested in September 2015. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out in June 2015.
- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received training. The last infection control audits were undertaken in December 2014 and we saw

Good

Are services safe?

evidence that action was taken to address any improvements identified as a result. For example we saw that carpets in the waiting area had been deep cleaned and plans were in place to replace them with washable compliant flooring. Cleaning records were kept which showed that all areas in the practice were cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. Medicines were stored in medicine refrigerators in the nurse's treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. The GPs and nurses shared latest guidance on medication and prescribing practice at weekly clinical meetings, for example the prescribing of antibiotics. The practice takes part in monthly benchmarking meetings with other GP practices in West London.
- Recruitment checks were carried out and the seven staff files we reviewed 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.
- The practice manager told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The practice manager occasionally provided cover in reception during busy periods.

Arrangements to deal with 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 did not have a defibrillator available on the premises but had carried out a risk assessment which stated that rapid response paramedics could be at the practice within a couple of minutes. There was oxygen with adult and children's masks. 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 had a continuity and recovery plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for suppliers.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The GPs told us they had "hot topics" course web links on desktops. The practice had access to guidelines from NICE and any changes were cascaded to the GPs and nurses who used this information to develop how care and treatment was delivered to meet needs. GPs at the practice also attended monthly clinical learning sets with 12 other local practices.

GPs told us they would continually review and discuss new best practice guidelines for the management of all conditions. We reviewed some clinical meeting minutes and confirmed that this occurred. For example, the practice had recently received a guideline on Meningitis B for infants advising that paracetamol had to be given 30 minutes before the appointment time. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

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. GPs told us they were committed to maintaining and improving outcomes for patients. The practice scored 93.1% and for 2013-2014 which was 4.1% above the CCG average but 0.4% below the England average. They had a 13% exception reporting.

The QOF data showed;

- Performance for diabetes related indicators was 88% which was 2.2% above the CCG but 1.5% below national average.
- The percentage of patients with hypertension having regular blood pressure tests was 95% which was 8% above the CCG and 7% above national average.
- The dementia diagnosis rate was 80%, which was 10% below the CCG and 13% below the national averages.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been six clinical audits completed in the last year where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, one GP had audited to ensure that diclofenac prescribing is safe and appropriate as there was an increased risk of thrombotic events when using this medication. They looked at all patients receiving diclofenac and considered age, whether they were regular users or 'as and when' and any contraindications. There were nine patients initially identified. Alternative medication was recommended for four patients. After re-audit they found that the amount of people taking this medication had reduced and that appropriate regular monitoring of patients being prescribed this drug took place.

The practice participated in applicable local audits and national benchmarking.

Effective staffing

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

- The practice had an induction programme which covered a wide range of topics such as health and safety, infection control, safeguarding and fire safety.
- 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, 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
- Staff also completed regular mandatory courses such as annual basic life support and health and safety training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics.
- Staff had access to additional training to ensure they had the knowledge and skills required to carry out their roles and for career development. For example, reception staff had received appropriate training to become health care assistants.

Good

Are services effective?

(for example, treatment is effective)

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. 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 people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they are 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 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. 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. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

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. Patients were then signposted to the relevant service. A care coordinator was available at the practice one days a week. We saw that four patient's risk scores had reduced after three months of being supported by the care navigator.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 79%, which was similar to the CCG average and just below the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test and the care coordinator had recently taken on this task to help improve these rates. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

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 64% to 80% and five year olds from 52% to 80%. Flu vaccination rates for the over 65s were 62%, and at risk groups 34%. The practice was aware that these were below the CCG and national averages and had put in processes to try to improve these outcomes.

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 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 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. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 29 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2014 and the friends and family survey. The evidence from both these sources showed patients were satisfied with their experience at the practice. For example,

- 93% of patients who responded described their overall experience as good as compared to the local average of 85% and the national average of 85%.
- 93% of practice respondents saying the GP was good at listening to them as compared to the local average of 89% and the national average of 88%.
- 91% said the GP gave them enough time as compared to 85% and 87% respectively for the CCG and the national average
- 91% said the last nurse they spoke to was good at treating them with care as compared to the local average of 87% and the national average of 90%.
- 86% patients said they found the receptionists at the practice helpful which were comparable to the CCG and national averages.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice good in this area. For example, data from the national GP patient survey from 2014 showed 83% of practice respondents said the GP involved them in care decisions compared to 81% for the CCG and 81% nationally. The care plans we reviewed clearly demonstrated that patients were involved in the discussions and agreeing them. There was evidence of end of life planning with patients.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received with all GPs. They also told us they felt listened to and supported by all other staff and were given enough information to make informed decisions about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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 areas informing patients this service was available

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and information on the practice website sign-posted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carers were asked to complete a carer's forms where appropriate and there were written information available for carers to ensure they understood the various avenues of support available to them.

There was a system of support for bereaved patients both provided by the practice and other support organisations. GPs told us they would make phone calls to families who had suffered bereavement. People were given the option to be referred for bereavement counselling or signposted to a support service. Patients we spoke with who had been bereaved confirmed they had received this type of support and said they had found it helpful. Deaths of patients were discussed at the weekly clinical and monthly practice meetings.

The practice maintained a list of patients receiving end of life care and this was available to the out of hour's provider.

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 CCG to plan services and to improve outcomes for patients in the area. For example, the practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised. The practice also engaged with CCG led audits and benchmarking to monitor services and improve outcomes for patients and data showed the practice was performing in line with local averages.

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;

- Patients over 75 years had a named GP to co-ordinate their care. The practice was part of the whole systems integrated care (WSIC) pilot and held WSIC clinics for over 75s which were attended by GPs, district nurses and social services care coordinators. They had a list of older people who were housebound, whom they would visit regularly, particularly frail older patients.
- A Primary Care Navigator was based at the practice one day a week, to support older patients and their carers to access timely care and community support. Their role included befriending, attending patients' homes, liaising with social services and acting as advocates.
- The practice had clinical leads for a variety of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease. The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. GPs attended regular internal as well as multidisciplinary meetings with district nurses, social workers and palliative care nurses and consultants on occasions, to discuss patients and their family's care and support needs. Patients in these groups had a care plan and would be allocated longer appointment times when needed. They are reviewed every six months and we saw where results were outside the normal range appropriate action was taken. They were then monitored closely before patients were returned to normal review periods. Services such as spirometry, smoking cessation, phlebotomy, ECG and anticoagulation monitoring are also provided by the practice.
- The practice took part in a mother and baby monthly Paediatric Hub Clinic in partnership with other GP practices and consultant paediatricians from the local hospital. The practice ran a weekly mother and baby and baby immunisation clinics which provided an opportunity for mothers to express any concerns to the GP or nurse that they may have. The nurse told us they liaise regularly with health visitor who also attend some Multi-Disciplinary Team Meetings.
- The practice offered appointments on the day for all children under 5's when their parent requests the child to be seen for urgent medical matters. The GPs demonstrated an understanding of Gillick competency and told us they promote sexual health screening.
- The GPs told us that patients whose circumstances may make them vulnerable such as the homeless, those under safeguarding or people with learning disabilities were offered regular health checks and follow-up. They said they would also refer them to other agencies including Improving Access to Psychological Therapies (IAPT, Mind, and Carers Groups. Any patients who were deemed vulnerable were also brought to the weekly clinical meeting by the relevant clinician and discussed. The practice looked after a local homeless hostel and saw these patients regularly to enable early identification of physical health deterioration and prevent onward referral to secondary care.
- The practice ran evening clinics twice a week which they told us was particularly popular with their working age patients. They also offered extended appointments, on-line booking of appointments, online ordering of repeat prescriptions and telephone consultations to speak with the GP or nurse in relation to test results.
- The GPs told us that patients with poor mental health had input from the community mental health teams (CMHT). They also had a primary care liaison nurse for mental health based at the practice one day a week. Their role was to support patients with mental illness transition from secondary care to primary care to ensure a safe discharge process. They would also see patients referred to them from the practice. We saw they would refer patients to Improving Access to Psychological

Good

Are services responsive to people's needs?

(for example, to feedback?)

Therapies (IAPT), support patients themselves or refer directly to the acute brief assessment team in the local hospital. Where appropriate, longer appointments were offered.

- One GP was the substance misuse lead and the practice screened patients opportunistically for hazardous and harmful drinking, and referred those with addiction problems to our to their in-house substance misuse clinic or to the community drug and alcohol clinic.
- The premises were accessible to patients with disabilities. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access. All consultation rooms were on the ground floor. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

The practice was open from 8.00am to 6.00pm Mondays, Thursday and Friday. They had extended hours on Tuesday and Wednesday, where they opened to 8.30pm. The telephones were manned from 8.00am to 6.00pm Mondays to Fridays excluding Tuesday and Wednesday when they were answered up to 8.30pm, a recorded message was available at all other times. Appointment slots were available throughout the opening hours. Longer appointments were available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Feedback from the national GP survey published in 2014 was positive about the appointment system. For example;

- 83% of respondents described their experience of making an appointment as good and
- 86% were satisfied with the surgery's opening hours.

Feedback from completed Care Quality Commission (CQC) comment cards was also positive about the appointment stating they could always get an appointment when needed.

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. The practice manager handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and a summary leaflet was available and given to patients when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample complaints received in the last 12 months and found these were dealt with in a timely way in line with the complaints policy and there were no themes emerging. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, we saw that where a patient had complained about breaching confidentiality the practice investigated and reviewed its procedure in relation to getting consent.

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 manager told us their vision was to provide high quality health care in a caring environment with particular emphasis being placed on disease prevention and management. They said they aimed to deliver a high standard of patient care, be committed to patient needs and be transparent and accountable to them. Staff we spoke with understood the vision and said they felt the practice delivered high quality care, promoted good outcomes for patients and continually tried to make improvements. We found staff were clear about their responsibilities in relation to providing good care at the practice.

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 leadership structure with named members of staff in lead roles. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.
- The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. All five policies and procedures we looked at had been reviewed annually and were up to date.
- The practice held weekly management meetings which were attended by the partners and the practice manager. We looked at notes from these meetings and found that performance, quality, staffing and building maintenance had been discussed.
- The practice had a comprehensive understanding of their performance. They attended a monthly peer review meeting with other practices and used the Quality and Outcomes Framework (QOF) to measure their performance, which showed it was performing in line with national standards. Staff told us QOF data was regularly reviewed and discussed at the practices monthly meetings.
- There was a programme of continuous clinical and internal audit used to monitor quality and to make improvements. Further, there were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had risk assessments in their records.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always takes the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held and that there was an open culture within the practice. They said they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. 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 delivered by the practice.

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through patient surveys, friends and family test and complaints received. We looked at the results of the in-house patient survey from March 2015 and saw that one area reviewed was patient's awareness of practice opening hours. As a result the practice had put posters in the waiting room, updated the practice leaflet and updated the practice website.

The practice had a virtual patient participation group (PPG) and we saw that there were more than 40 patients in the group. The practice manager told us they were planning to have the first physical meeting in November 2015.

The practice had also gathered feedback from staff through staff meetings and appraisals. Staff told us they would not

Are services well-led?

Good

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

hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example they were a training practice for both GPs and nurses and at the time of our inspection employed two GP's in training.

The practice had also set up an apprenticeship scheme for administrative staff and had employed four trainees to date, two of whom had gone on to become permanent workers at the practice.