Haden Vale Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Haden Vale Medical Practice on 28 April 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. However, learning was not always shared with all staff members.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- 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.
- Most patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

The practice employed an 'elderly social care co-ordinator' who organised coffee mornings every two weeks and trips away. We saw that a group of patients had gone away during Christmas and another residential event was planned for the summer. The elderly care co-ordinator also acted as an advocate to access other social services and visited patients in their homes. Some patients told us that the social events and coffee

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mornings helped them deal with bereavement and other issues they had experienced. They told us that the activities of the care co-ordinator had made a positive impact on their physical and mental wellbeing as they could access peers for support through the activities organised.

The areas where the provider should make improvement are:

- Ensure learning from all incidents, significant events and complaints are shared appropriately with staff to prevent re-occurrence
- Ensure emergency equipment is being checked regularly to confirm they are in working order.
- Ensure practice performance for diabetes and mental health related indicators are improved.

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. There was an effective system in place for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Evidence looked at showed lessons were shared to improve safety in the practice for some incidents. The practice had defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Risks to patients were assessed and well managed. Equipment was regularly serviced and maintained through external contractors. However, emergency equipment was not regularly checked to confirm they were in working order.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to local and national averages for most domains. Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. There was evidence of appraisals and personal development plans for all staff. Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from the national GP patient survey showed patients rated the practice comparable to other practices locally and nationally 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. The practice employed an elderly care co-ordinator who organised regular coffee morning and social events. They visited patients at home and also acted as an advocate to access other social services. Information for patients about the services available was easy to understand and accessible. We observed a friendly atmosphere throughout the practice during our inspection. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical

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Commissioning Group to secure improvements to services. For example, the practice was taking part in the Primary Care Commissioning Framework (PCCF), a CCG initiative to help deliver improvements in clinical outcomes for patients. Most patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. To improve access and reduce delays the practice had introduced a telephone triage system. 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 the practice responded quickly to issues raised. However, learning from complaints was not regularly shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it. 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 was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings. The practice taught medical students and had a vision to become a teaching practice for trainee GPs. As part of the vision to improve and offer more services the practice had plans in place to extend the premises.

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. 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 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 employed an elderly care co-ordinator who also visited patients in their homes and acted as an advocate to access other social services. They organised coffee mornings every two weeks for the elderly and their carers. Records we looked at showed that it was well attended with 20 or more people attending. The coffee morning was subsidised by the practice. The elderly care co-ordinator also organised other social events. For example, during Christmas a group of patients had gone to Devon for four days and this was organised by the care co-ordinator.

The practice had effective systems in place to identify and assess patients who were at high risk of admission to hospital. These patients were reviewed and care plans developed to reduce the need for them to go into hospital.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The practice had recently employed a nurse and they had a lead role in chronic disease management such as diabetes and COPD. We saw that achievement for diabetes and COPD indicators were significantly lower compared to local and national averages. The GPs carried out reviews for diabetes and COPD before the nurse started. We were told that although reviews were being carried out they were not always recorded and were not as structured.

Longer appointments for conditions such as diabetes were available and home visits were available when needed. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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

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A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. The practice offered a full family planning service and offered coil and implants service. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw positive examples of joint working with midwives and health visitors.

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 operated extended hours service which was useful for parents with children and those who worked. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected 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 those with a learning disability. The practice offered longer appointments for patients with a learning disability.

The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice informed 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). The practice regularly worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Information was made available at the practice to sign post patients to various support groups and

Summary of findings

services. This was also available on the practice website. 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.

Data we looked at showed that the practice achievement for mental health QOF indicator was significantly lower. We were told that the practice found it difficult to engage some patients and the practice did not have a nurse for a significant period which also contributed to this.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice performance was slightly higher that the local and national averages in some areas. Of the 345 surveys forms distributed t, 111 were returned. This represented 32% completion rate.

- 92% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 88% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 90% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 84% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 86 comment cards, most of which were positive about the standard of care received. Most patients said they received an excellent service from doctor and reception staff. They said they were given good advice in a calm, relaxing and welcoming environment.

We spoke with five patients during the inspection. Most patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, some patients said that they there was often a long wait for a particular GP.

Areas for improvement

Action the service SHOULD take to improve

- Ensure learning from all incidents, significant events and complaints are shared appropriately with staff to prevent re-occurrence
- Ensure emergency equipment is being checked regularly to confirm they are in working order.
- Ensure practice performance for diabetes and mental health related indicators are improved.

Outstanding practice

The practice employed an 'elderly social care co-ordinator' who organised coffee mornings every two weeks and trips away. We saw that a group of patients had gone away during Christmas and another residential event was planned for the summer. The elderly care co-ordinator also acted as an advocate to access other social services and visited patients in their homes. Some patients told us that the social events and coffee mornings helped them deal with bereavement and other issues they had experienced. They told us that the activities of the care co-ordinator had made a positive impact on their physical and mental wellbeing as they could access peers for support through the activities organised.

Haden Vale Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Haden Vale Medical Practice

Haden Vale Medical Practice provides medical services to approximately 5600 patients in the local community of various ages. There are two GP partners (one male and one female) and two salaried GPs (one male and one female). The practice is based in the Cradley Heath area of the West Midlands.

The GPs are supported by a practice nurse who had started three weeks prior to our inspection visit. The practice had advertised to recruit a healthcare assistant (HCA) as the Clinical Commissioning Group (CCG) funded HCA had left in February 2016. The non-clinical team consists of a team of administrative and reception staff and a practice manager. The practice also had medical students from the local university.

Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients.

The practice is open between 8am and 6.30pm Mondays to Fridays and extended hours appointment is offered from 6.30am to 8pm on Tuesdays. The practice has opted out of providing out-of-hours services to their own patients. This service is provided by 'Primecare' the external out of hours service provider.

We reviewed the most recent data available to us from Public Health England which showed that the practice is located in an area with a higher deprivation score compared to other practices nationally. Data showed that the practice has a lower than average practice population aged 50 years and over in comparison to other practices nationally. The practice also has a slightly higher than the national average number of patients aged between 0 to 15 and 25 to 50.

The practice achieved 85% points for the Quality and Outcomes Framework (QOF) for the financial year 2014-2015. This was below the local average of 93% and national average of 95%. The QOF is a voluntary annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 April 2016.

During our visit we spoke with a range of staff including the GP partners, the practice manager, the practice nurse and administration staff. We also spoke with patients who used the service including members of the Patient Participation Group (PPG). We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

The practice had systems in place to monitor safety and used a range of information to identify risks and improve patient safety. This included reporting incidents, acting on national patient safety alerts and comments and complaints received from patients. For example, we saw that the practice had recorded eight significant events in the last year. Two of the incidents related to cold chain events where the door to the medicine fridge was found open. The practice identified that the fridge lock had broken and the vaccines were not used. All patients were contacted and had their appointments re-arranged. This was reported and also shared with the Clinical Commissioning Group (CCG) using the electronic recording system. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. Staff members we spoke with were aware of the reporting process and confirmed that learning from incidents were shared with them. However, we saw that some incidents that were recorded had not been discussed to share learning.

The practice received patient safety alerts. Records of relevant alerts were kept with record of taken in response.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe. Arrangements were in place to safeguard vulnerable adults and children from abuse. There was a lead member of staff for safeguarding. Staff members we spoke with were aware of the safeguarding lead in the practice should they needed to seek advice or support. Staff demonstrated they understood their responsibilities and had access to relevant polices. Policies contained contact details of relevant agencies responsible for investigating safeguarding concerns. There was a system to highlight vulnerable patients on the practice's electronic records and we saw examples of these. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Minutes of meetings looked at showed that safeguarding was discussed with health visitors. The GPs we spoke with confirmed that they attended external safeguarding meetings when possible and always provided reports where necessary for other agencies. GPs were trained to child protection or child safeguarding level 3 and other staff had appropriate safeguarding training for their role.

Notices in the practice as well as on the practice website advised patients that chaperones were available if required. Usually clinical staff acted as chaperones but administration staff we spoke with confirmed that they had acted as a chaperone. They confirmed that they were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and 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. However, emergency equipment (medical oxygen and the defibrillator) were not being checked regularly.

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was who had started three weeks earlier was appointed the infection control lead and had completed online infection prevention training (with further training planned) to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. We saw that an annual infection control audits was undertaken by the practice manager in April 2016. We saw that the practice nurse had undertaken a recent handwashing audit and had identified actions to address improvements that were required.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits with the support of the local CCG pharmacy teams to ensure prescribing was in line with best

Good

Are services safe?

practice guidelines for safe prescribing. We saw Patient Group Directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. We saw that these had been signed by the nurse and the manager.

Monitoring risks to patients

Risks to patients were assessed and well managed. There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the staff area which identified local health and safety representatives. 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 (COSHH). A legionella risk assessment was completed in March 2016. Legionella is a term for particular bacteria which can contaminate water systems in buildings. The practice had a health and safety policy in place and had conducted an organisational risk assessment in April 2015.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff members we spoke with told us that they provided cover for. The practice had recruited a nurse recently and was in the process of employing another salaried GP. A healthcare assistant (HCA), funded by the CCG had worked at the practice but had left in February 2016 after the funding was withdrawn. The practice intended to employ a HCA and had advertised for the role.

Arrangements to deal with emergencies and major incidents

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

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. This was confirmed by the staff members we spoke with. All staff received annual basic life support training and there were emergency medicines available. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit was available and emergency medicines were easily accessible to staff in a secure area of the practice. All the medicines we checked were in date and stored securely and all staff members we spoke with knew where they were located. However, we did not see evidence that the emergency oxygen and defibrillator were being checked regularly to ensure it was in working order. Staff members told us that they were checking but were not documenting these checks. The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The business continuity plan incorporated use of alternative premises nearby from the Salvation Army. We were told that this had been utilised previously as part of the plan.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE online and used this information to deliver care and treatment that met patients' needs. Clinical staff members we spoke with were able to discuss and show us specific NICE guidance in relation to diabetes.

The practice monitored that guidelines were followed through risk assessments, and audits and random sample checks of patient records. For example, we saw that an audit had been carried out on type 2 diabetic patients to check if they were being started on treatment according to NICE guidance. The lead GP told us that they were able to link NICE guidance to specific patient records where appropriate.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 85% of the total number of points available. The practice exception reporting was at 6%, this was 3% below local CCG average and 4% below national average. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

Data from 2014/15 showed:

- Performance for diabetes related indicators was lower compared to the national average. For example, the practice overall achievement diabetes related indicators was 74%. This was 11% below the CCG average and 10% below the national average.
- Performance for mental health related indicators was lower compared to the local and national average. The practice achievement for mental health related outcomes was 55%. This was 34% below local CCG average and 38% below national average.

The practice percentage of patients with chronic obstructive pulmonary disease (COPD), who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (2014/15), was also significantly lower than the local and national average. The practice achieved 68% compared to the national average of 90%. We spoke with the lead GP who told us that the practice nurse had started three weeks previously and before that they had employed a nurse in April 2015. However, they were from the hospital and had not worked in primary care. They were not trained on COPD and the GPs at the practice reviewed these patients. Consequently they felt that reviews were being undertaken but the recording was poor which contributed to the low figures. The new practice nurse employed had a diploma in COPD and it was thought that this would help improve outcomes.

Similarly, the lead GP agreed that more organised reviews were required for mental health and diabetes patients. However, they again felt that reviews were being done (by GPs) but they were not completing appropriate administration processes on the system to register that a review had taken place. We spoke with the practice manager who told us that they had appropriate follow up procedures for mental health patients but found them difficult to engage and the absence of a nurse did not help.

The practice manger explained that the previous nurse was employed in April 2015 and they were from the hospital and had not worked in primary care. They were supported through attendance of relevant courses to help them adjust and as a result they were not carrying out their full role. However, the nurse had left in July 2015 and the practice found it difficult employ another nurse until recently. They felt this had contributed to the low Quality and Outcomes Framework (QOF) figures.

There was evidence of quality improvement including clinical audit. There had been five clinical audits completed in the last two years. For example, the practice had undertaken a heart failure audit in 2014 and a re-audit was carried out in 2015. We saw that a pre diabetes audit had been carried out. A specialist diabetes nurse held clinics

Good

Are services effective?

(for example, treatment is effective)

with a consultant from the local hospital for complex cases. This was a CCG initiative and a combined audit was done. We saw that medicines management audit had been done on anti-inflammatory medicines and nutritional supplements. Findings were used by the practice to improve services. For example, the heart failure audit identified actions to improve patient outcomes. The practice had conducted a contraceptive implant fittings audit between February and September 2013. A second cycle of the audit between July and December 2015 showed improvements in record keeping.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for all newly appointed staff. The practice nurse had started three weeks earlier and confirmed that they had an induction, had access to the lead GP for any advice and were being supervised. They confirmed that the induction covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The practice also had an induction pack for locum GPs.

The practice was proactive in providing training to staff. Staff had access to appropriate training including online training to meet their learning needs. Staff had access to and made use of e-learning training modules and in-house training. This included core training in areas such as safeguarding children and vulnerable adults, basic life support and infection prevention and control. Staff had received training and updates relevant to their role, for example the GPs had received level three safeguarding children's training.

The practice nurse had started three weeks earlier and told us that they were receiving mentorship and support from the lead GP. They told us that the lead GP was due to review and supervise patients they had seen to ensure competence. The told us that they had access the lead GP if they had any questions. They told us that they were seeing some patients with the GP to build their confidence.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example the practice nurse told us that they attended clinical meetings where new practices and cases were discussed.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support and clinical supervision for the nurse. Documents we looked at confirmed that all relevant staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.

The practice shared relevant information with other services in a timely way, for example when referring patients to other services or communicating with the out of hours (OOH) provider for patients on the end of life care register. The GP told us that the computer system used by the practice was linked with the OOH care providers system.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a six to eight week basis when care plans were routinely reviewed and updated for patients with complex needs. We saw evidence that vulnerable patients, unplanned admissions as well as patients on palliative care were discussed and action plan developed.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. This included training in deprivation of liberty

Good

Are services effective?

(for example, treatment is effective)

safeguards (DoLS). We saw evidence that staff had attended training in MCA within the last two years. Our discussion with staff demonstrated that they understood the relevant consent and decision-making requirements of legislation when providing care and treatment and would act on any concerns about a person lacking capacity to consent. This included Gillick competence (the Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

When providing care and treatment for children and young people, written consent was obtained from parents.

When providing care and treatment for children and young people, written consent was obtained from parents.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, those requiring advice on their diet, smoking cessation and sexual health advice. The practice provided full contraceptive services including coils & implants. A stop smoking service was provided at the practice weekly.

The practice had a secondary prevention health advisor who helped and supported patients detecting the early stages of disease, intervening where appropriate. The practice had an elderly social care coordinator who also acted as an advocate to help and support older patients access other services.

The practice's uptake for the cervical screening programme was 86%, which was better than the CCG average of 82% and 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 demonstrated how they encouraged uptake of the screening programme by advising patients to have cervical screening regularly in the practice and on their website.

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 97% to 100% and five year olds from 97% to 100%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Most staff had been employed at the practice for a long time and knew their patients well. We saw staff members treat a child with a long term condition with kindness and compassion. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations; 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.

We received 86 patient Care Quality Commission comment cards. Most of the comments cards were positive about the service. Generally, patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

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

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

- 81% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%).
- 90% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%)
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%).
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%).
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%)

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey showed the practice score to questions about their involvement in planning and making decisions about their care and treatment was below local and national averages. For example:

- 76% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 73% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%)

The practice provided facilities to help patients be involved in decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language. However, we did not see any posters in the reception areas informing patients that this service was available.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

Good

Are services caring?

Counselling service was available at the practice twice weekly provided by the CCG and through referral by the GP.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 226 patients as carers (4% of the practice list) and offered additional support and health checks. The practice offered free carers assessment and referred carers to other services where appropriate. The practice website also directed carers to appropriate support available. The practice also published a quarterly newsletter with information on services and changes to the practice and personnel. We saw that the spring newsletter contained information for carers such as contact details for local and national agencies.

The practice employed an elderly social care co-ordinator. They were trained as a healthcare assistant (HCA) and their heir main focus was patients over the age of 75. They carried out healthchecks, visited patients at home to carry assessments such as dementia screening and falls risks. Any social care needs were arranged by speaking with social workers and filling in appropriate forms. They also acted as an advocate and referred patients to other services such as befriending and age well.

The care co-ordinator organised a 'coffee morning club' every two weeks at the practice for patients, particularly the elderly. Carers were invited to attend this event. The coffee morning also supported carers to access other avenues of support. Records we looked at showed that over 20 people regularly attended the event. This was subsidised by the practice and staff told us that they often brought in cakes.

The elderly care social co-ordinator also organised trips away. We were told by staff and patients that a group of patients had gone away for four nights during Christmas 2015. We were told that another holiday was being organised in the summer. Some of the patients we spoke with were very positive about the care co-ordinator and their role. Some patients told us that the social events and coffee mornings helped them deal with bereavement and other issues they had experienced. They also met with bereaved family members and offered access to other support available

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. For example, the practice was taking part in the primary care commissioning framework (PCCF). As part of this, the practice was expected to offer various services such as end of life care and to improve on management of long term conditions.

The practice had a secondary prevention health advisor who helped and supported patients detecting the early stages of disease, intervening where appropriate. The practice had recognised the need for this and could demonstrate the positive impact on patient outcomes. As a result they were able to secure CCG funding for this.

However, the practice achievement for dibetes and mental health related Quality and Outcomes Framework (QOF) indicators were significantly lower compared to local and national averages. As a result we have rated the population group for people with long-term conditions as requiring improvement**.** The practice explained that the practice nurse had left and this contributed to the low figures.

The practice was open late from 6.30pm to 8pm on Tuesdays and home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The elderly care co-ordinator also visited patients at home and acted as an advocate to access other social services.

There were longer appointments available for patients with a learning disability. The practice nurse told us that they offered longer appointments for patients with complex long term conditions such as diabetes. Same day appointments were available for children and those patients with medical problems that require same day consultation. Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately. A telephone consultation service had recently been established and online appointments were also available.

There were disabled facilities and patients using a wheel chair could access the practice, there was designated disabled parking and part of the reception desk was lowered. For patients who did not speak English, a translations service was available. A hearing loop was available for patients who had a difficulty with their hearing and staff were aware of how to operate the device.

The practice building was being extended and we were shown the plans that had been submitted. As part of the extension, the plan was to have automatic sliding doors for better access for patients using a wheelchair.

Access to the service

The practice was open between 8am and 6.30 Monday to Friday. Appointments were from 8.30am to 12pm every morning and 2.30pm to 6pm daily. On Tuesdays extended hours appointments were offered from 630pm to 8pm. 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.

We received 86 patient Care Quality Commission comment cards. Most of the comments cards were positive about the service. However, nine comments cards also stated that they occasionally struggled to get an appointment at a time they required. The practice was aware of this had introduced a telephone triage system to improve access.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was slightly better compared to local and national averages.

78% of patients were satisfied with the practice's opening hours compared to the local CCG average of 71% and the national average of 75%.

- 92% of patients said they could get through easily to the practice by phone compared to the local CCG average of 62% and the national average of 73%.

Most patients told us on the day of the inspection that they were able to get appointments when they needed them. Most of the comments cards we received also confirmed this.

The practice had a system in place to assess whether a home visit was clinically necessary. Generally patients needed to call before 11.30am to request a home visit. A telephone triage service was introduced recently to determine the urgency of the need for medical attention. If a patient contacted the surgery requesting an urgent on

Good

Are services responsive to people's needs?

(for example, to feedback?)

the day appointment, reception staff would request basic information which was logged and passed onto the nominated triage GP for the day. Patients then received a call back to assess over the telephone and where appropriate received advice, a prescription or an emergency appointment on the day. One of the reasons this had been introduced was to improve access by reducing unnecessary access and waiting time for the GPs. Although formal audits were not yet being undertaken, the practice manager told us there was an improvement as more patients were seen and informal feedback from patients also suggested improvement.

Listening and learning from concerns and complaints

The practice had an effective 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 was the designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. The complaints procedure was displayed in the practice waiting area and the practice leaflet. Patients could also access the complaints policy and procedure on the practice website.

We looked at seven complaints received in the last 12 months and found that they were responded to appropriately. For example, in September 2015 a patient had complained regarding delays in being seen after their appointment times. We saw that the practice had responded timely and apologised to the patient. As part of the learning the practice had introduced a new triage system to reduce unnecessary access. We noted that some, but t not all complaints were being discussed in team meetings to share learning.

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 strive for excellence and endeavour to meet the needs of the whole person through the provision of general medical services. Staff members we spoke with were aware of the vision of the practice and told us that they had discussed this at a recent practice meeting. Staff members told us that one of the vison of the practice was to extend the building so that more services could be offered. The lead GP told us that medical students were offered placements at the practice and they planned to become a teaching practice for trainee 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. An understanding of the performance of the practice was maintained. For example, the practice was aware that waiting times for appointments needed to be improved. As a result of this a telephone triage system was piloted and introduced. The practice was also aware that their achievement for some QOF indicators needed improvement and recruited a practice nurse recently.

There was a clear staffing structure within the practice with a lead roles such as infection control and long term disease management

Practice specific policies were implemented and were available to all staff. Staff members demonstrated to us how they accessed policies in the practice.

A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised high quality, safe and professional service with an emphasis on prevention and promotion of health and wellbeing. We saw that this was reflected through the roles of the elderly care co-ordinator and the as the secondary prevention health advisor. Most of the staff had been long standing told us that they enjoyed working at the practice and felt part of a motivated team. Staff also told us the partners were approachable and always took the time to listen to all members of staff. They were always asked for their opinions to improve practice in team meetings.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment, the practice gave affected people reasonable support, truthful information and a verbal and written apology. For example, we looked at complaints and saw that the practice had responded to a patient with an apology because they had waited too long after their appointment time.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, For example, the General Practice Assessment Questionnaire (GPAQ) survey conducted by the practice for 2014/15 as well 205/16 identified issues with waiting time to see a GP. Minutes of PPG meeting we looked at for September 2015 showed that the PPG had also highlighted this. The practice proposed to introduce a pilot telephone triage scheme and sought feedback from the PPG. Minutes

Are services well-led?

Good

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

of PPG meeting held in March 2016 confirmed this. The PPG fed back that some individuals were not at home to take calls from the GP and wanted the practice to highlight this to patients through a poster in the reception area.

Staff told us they were always asked for feedback during meetings and they also told us that the lead GP was very approachable and was very supportive.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice aimed to become a teaching practice and planned to expand the building to offer more services. The practice used evidence to support the need to have a secondary health advisor funded by the CCG.