

# Drs Shah and Partners

## 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

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Shah and Partners, also known as Trinity Medical Centre name on 20 March 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events which staff understood.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance.
- Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect although the figure for being involved in decisions about their care and treatment was below the local and national average for GPs.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Ensure systems to ensure patient group directives are signed by the same designated person.
- Ensure care plans for patients with asthma contain all the required information, including what the patient should do in the event of an emergency.
- Develop a schedule of audit in relation to patients' health and treatment needs rather than those required by the Clinical Commissioning Group.

# Summary of findings

- Record verbal complaints to include actions taken.

**Professor Steve Field CBE FRCP FFPH FRCGP**  
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of and followed current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Good



### Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Good



# Summary of findings

- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example they invited the specialist diabetic nurse to attend the practice to review patients and one of the GPs provided ear, nose and throat appointments at the practice.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from five examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. Verbal complaints were not recorded, but dealt with at the time.

Good



## Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In four examples we reviewed we saw evidence the practice complied with these requirements.

Good



# Summary of findings

- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people.

- Staff were able to recognise the signs of abuse in older patients and understood their responsibility to report any concerns.
- The practice offered proactive and personalised care to meet the needs of the older patients in its population. One GP was assigned to triage home visits for patients who rang requesting these.
- The practice was responsive to the needs of older patients, they offered home visits and urgent appointments for those with enhanced needs.
- The practice identified older patients who may need palliative care as they were approaching the end of life. They involved older patients and their relatives and carers where relevant in planning and making decisions about their care, including their end of life care.
- The practice followed up when older patients were discharged from hospital and ensured any care plans were updated to reflect any changes in needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

Good



### People with long term conditions

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

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Overall, performance for diabetes related indicators was below the CCG and national average. The practice were aware of this and had developed an action plan to improve. This included changing their recall system, the diabetic specialist nurse attended to support the practice nurses and recruiting a GP with special interest in diabetes. Their exception reporting rate overall for diabetes indicators was 6% compared to a CCG average of 8% and national average of 12%. The practice held specialist diabetic reviews for patients with complex diabetes.

Good



# Summary of findings

- The practice followed up when patients with long-term conditions were discharged from hospital and ensured that their care plans were updated to reflect any changes to their needs.

All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met through the local PACT (Put All Care Together) system which offered a 45 minute appointment where goals were identified and agreed. 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**

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

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and in response to identified need, the practice offered a dedicated children's clinic three times a week. The premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, providing ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Good



## **Working age people (including those recently retired and students)**

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

Good





# Summary of findings

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care, for example, extended opening hours three evenings a week and Saturday appointments.
- The practice was proactive in offering online services for booking appointments and repeat medicines requests as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice saw students who left the area to attend university as temporary patients when they returned home for holidays.

## People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information displayed for vulnerable patients about how to access various support groups and voluntary organisations and clinical staff gave relevant leaflets during consultations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



## People experiencing poor mental health (including people with dementia)

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

- The practice carried out advance care planning for patients living with dementia.

Good



# Summary of findings

- 84% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the CCG average 90% and national average of 84%.
- Patients at risk of dementia were identified and offered an assessment.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia and worked with local specialist services to ensure joined up care and treatment.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice had 127 patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses, and had recorded a comprehensive care plan for 88% of these patients, compared to a CCG average of 90% and national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and ninety two survey forms were distributed and 111 were returned. This represented just over 1% of the practice's patient list.

- 86% of patients described the overall experience of this GP practice as good compared with the CCG average of 88% and the national average of 85%.
- 68% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.

- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 85% and national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards which were all positive about the standard of care received. Patient comments included that staff were caring, friendly and professional and that there was a good service provided.

All of the seven patients who completed the NHS Friends and Family Test in the last six months indicated they would recommend this service to a relative or friend.

# Drs Shah and Partners

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

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

## Background to Drs Shah and Partners

Drs Shah and Partners, also known as Trinity Medical Centre provides primary medical services in Wandsworth to approximately 9530 patients and is one of 42 practices in Wandsworth Clinical Commissioning Group (CCG).

The practice population is in the fourth least deprived decile in England. The proportion of children registered at the practice who live in income deprived households is 16%, which is below the CCG average of 20%; and for older people the practice value is 23%, which is the same as the CCG average. The practice age range of the practice's patients largely follow the same pattern as the local average with 17% under the age of 18 and 6% aged over 75. Of patients registered with the practice, 72% are of non-caucasian ethnicity.

The practice operates from a purpose built two storey premises. There is no parking at the practice, it is close to bus and underground stations. The reception desk and administrative office are on the ground floor, the main waiting area, and consultation rooms are situated on the first floor which is accessed by a lift. The practice manager's office, administrative offices, meeting room and staff kitchen are also on the first floor.

The practice team at the surgery is made up of three male and three female GPs who are partners and two nurses.

The practice is a teaching practice for medical students. In total the practice offers 45 GP sessions per week. The clinical team are supported by a practice manager, a senior and four administrators, a medical secretary and a senior and seven part time receptionists.

The practice operates under a General Medical Services (GMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments are from 8.30am to 11.30am, 2pm to 4pm and 4pm to 6.30pm daily. Extended hours appointments were offered from 6.30pm to 8pm Monday, Wednesday and Thursday and Saturdays from 9am to 11am. In addition to pre-bookable appointments that can be booked up to five weeks in advance, urgent appointments were also available for people that needed them.

When the practice is closed patients are directed to the local out of hours service.

The practice is registered as a partnership with the Care Quality Commission to provide the regulated activities of diagnostic and screening services; maternity and midwifery services; treatment of disease, disorder or injury; surgical procedures; and family planning.

The practice was inspected in December 2013 with issues identified with infection control because there was no audit or review of the cleaning carried out and issues with medicines management. A follow up inspection in April 2014 found the practice had made the required improvements.

# Detailed findings

## 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.

## 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 20 March 2017. During our visit we:

- Spoke with a range of staff including three GPs, two nurses, four administrative and reception staff and the practice manager.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

# Are services safe?

## Our findings

### Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out analyses of significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, after an immunisation was given at the wrong time, new systems were put in place including reception staff reminding patients to bring the immunisation schedule to their appointment and clinicians checking the immunisation schedule and patient record before giving immunisations to prevent a similar occurrence.
- The practice also monitored for trends in significant events at an annual meeting.

### Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were

accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.

- Staff spoken with demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3, nurses were trained to level 2 and reception and administrative staff to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff who acted as chaperones were clear about their role.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice manager and practice nurse were the infection prevention and control leads who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control policy and protocol and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, the last audit identified a cleaning schedule needed to be in place and chairs in reception needed to be wipe clean and we saw these had been completed. The audit identified carpets and taps needed replacing and the practice had an action plan in place to make these changes.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

## Are services safe?

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation, we found these were signed by the nurses but two were signed by different GPs which is not in line with guidance or the practice policy. Health care assistants were trained to administer vaccines and medicines under patient specific prescriptions or directions from a prescriber; these were produced appropriately.
- All electrical and clinical equipment was checked in June 2016 and calibrated in August 2016 to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients with arrangements in place to cover staff absence.

### Arrangements to deal with emergencies and major incidents

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

We reviewed the file of one newly recruited staff member and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

### Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment completed in June 2016 and carried out fire drills every six months. There were designated fire marshals within the practice who were clear about their role. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. The fire alarm went off during the inspection, staff and patients evacuated the building safely following their policy.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. These were tested regularly and staff spoken with knew the actions to take and gave an example of the system working.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### 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 91% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%.

The exception reporting was below both local and national averages in all areas. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2015 to March 2016 showed:

- Performance for diabetes related indicators was below the CCG and national averages. The practice were aware and were working through an action plan to improve the outcomes for these patients. For example, 65% (3% exception reporting) of patients had well-controlled diabetes, indicated by specific blood test results, compared to the CCG average of 74% and the national average of 78%.

- The percentage of patients with atrial fibrillation treated with anticoagulation therapy was 76% (5% exception reporting), which was below the CCG average of 85% and national average of 87%.
- Performance for mental health related indicators was in line with the CCG and national averages; 82% (0% exception reporting) of patients had a comprehensive agreed care plan documented compared with the CCG and national average of 89%.
- The number of patients with dementia who had received annual reviews was 84% (0% exception reporting) which was above the CCG average of 90% and national average of 84%.
- The number of patients with Chronic Obstructive Pulmonary Disease (COPD) who had received annual reviews was 92% (0% exception reporting) compared with the CCG and national average of 90%.

There was evidence of quality improvement including clinical audit:

- The practice has a rolling programme of audit working through those required by the CCG. There had been three clinical audits carried out in the last two years, two of which were completed in the last two years. While action plans had been developed and the findings of the audits shared amongst all clinical staff and the changes required were identified it was not always clear that these changes had led to improvements in patient care and treatment. Reviews of patients attending for minor surgery.

Two psychologists from the local mental health trust provided cognitive behavioural therapy to practice patients. One of the GPs carried out minor surgery including excision of skin lesions, biopsies and joint injections reducing the need for patients to attend their local hospital. One of the GPs provided a community based GP ear nose and throat clinic again reducing the need for patients to attend their local hospital and reducing the need for these appointments at the hospital.

### Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.



# Are services effective?

## (for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This included safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. We saw evidence that nursing staff had received training in topics such as spirometry, immunisation updates, travel health and infection control.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 16 months and plans were in place for these to be completed in the near future.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of four documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition, those with mental health conditions and those requiring advice on their diet and smoking and alcohol cessation.
- Patients were referred to local services for information on diet and smoking cessation.

The practice's uptake for the cervical screening programme was 80%, which was comparable with the CCG average of 79% and the national average of 81%. There was a policy to

## Are services effective? (for example, treatment is effective)

offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer. They had 66% of females aged 50-70 screened for breast cancer

in the last 36 months compared to the CCG average of 62% and national average of 72% and their uptake for bowel cancer screening was 52%, compared to a CCG average of 50% and national average of 58%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 85% to 89%.

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.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were kind, courteous, helpful and responsive to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same gender.

All of the 26 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

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

- 80% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the CCG and national average of 87%.
- 97% 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 92%

- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% national average of 85%.
- 83% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 91%.
- 87% of patients said the nurse gave them enough time compared with the CCG average of 90% and the national average of 92%.
- 96% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 90%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG and 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. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% 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 CCG average of 83% national average of 82%.

## Are services caring?

- 83% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 90%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 85%)

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.

### **Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs and all relevant staff if a patient was also a carer. The practice had identified 143 patients as carers (1.6% of the practice list). The practice prioritised these patients for appointments and provided a specific carer review appointment to ensure these patients were accessing the health and support services they needed. The practice also provided a carers newsletter which included a range of information to direct carers to relevant information and support.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation to best meet the family's needs and/or by giving them advice on how to find a support service.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population. They had 17% of their patient population aged under 18 and 6% aged over 75, 15% of patients were white British and 12% were Asian. The practice demonstrated how they met the needs of their population by having a regular children's clinic three days a week, by employing staff who spoke the locally used languages and by working with the local diabetic services to support the large number of patients with diabetes.

- The practice offered extended hours on a Monday, Wednesday and Thursday evening until 8pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- The premises were accessible. There was a hearing loop, and interpretation services available. A number of staff spoke different languages and were able to help with interpreting when required.

### Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11.30am, 2pm to 4pm and 4pm to 6.30pm daily. Extended hours appointments were offered from 6.30pm to 8pm Monday, Wednesday and Thursday and Saturdays from

9am to 11am. In addition to pre-bookable appointments that could be booked up to five months in advance, urgent appointments were also available for patients that needed them.

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

- 71% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 70% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 82% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 78% and the national average of 76%.
- 92% of patients said their last appointment was convenient compared with the CCG and national average of 92%.
- 68% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 45% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 58% and the national average of 57%.

The practice had a system to assess:

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

One of the GPs was responsible for ringing patients or carers who requested a home visit to gather information to help them decide if this was required. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

## Are services responsive to people's needs? (for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system with a leaflet at reception and details of how to make a complaint on the practice website.

We looked at five complaints received in the last 12 months and found they were satisfactorily handled, dealt with in a timely, open and transparent way. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, following a complaint about no-communication of prolonged waiting time reception staff were responsible for updating and apologising to patients for waits past patients appointment time.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a clear strategy which reflected the vision and values. Staff knew and shared the practice values and understood their responsibilities to work together to provide appropriate care and treatment to patients.

### Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example managing complaints, safeguarding, NICE, minor surgery and leading on infection control.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Weekly GP and monthly clinical meetings which provided an opportunity for staff to learn about the performance of the practice.
- Clinical audits were used to monitor quality and to make improvements, although those seen were from the CCG. There was no schedule of audits and nothing from the needs of the patient population.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example health and safety of the practice premises and fire safety risk assessments were carried out.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

### Leadership and culture

On the day of inspection the lead GP in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the lead GP was approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of four documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held a range of multi-disciplinary meetings including meetings with midwives, district nurses, the local hospice and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were kept and were available for practice staff to view.
- 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

# Are services well-led?

Good 

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

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

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, three times a year and carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG raised concerns with the practice about safety in the first floor waiting area as there was no member of staff posted there. The practice responded by having a member of staff positioned there to assist with patient enquiries and for response to emergencies.
- the NHS Friends and Family test, complaints and compliments received.

- staff through staff meetings and discussions. Staff told us they would not 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.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice was taking part in the 8 to 8 project for direct access for patients from NHS 111 and they carried out ear nose and throat (ENT) appointments at the practice which resulted in a decrease in the use of urgent ENT appointments at the local hospital.