

Wychall Lane Surgery

Quality Report

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Date of inspection visit: 2 September 2016
Date of publication: 31/10/2016

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wychall Lane Surgery on 2 September 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. Staff were aware of this and the practice as a whole demonstrated a commitment to learning from them.
- Risks to patients were assessed and well managed and there was evidence of thorough discussions regarding safety and risk issues. There was good use of information technology (IT) to facilitate management of risk in the practice. We noted that whilst there was evidence that safety alerts had been managed in the past, the ownership had not been transferred since the recent practice management changes. However, the

practice addressed this immediately, initiated discussions with all the partners and introduced a system to deal with safety alerts promptly and appropriately and provided evidence of this.

- Staff assessed patients' needs and delivered care in line with current evidence based guidance and we saw that discussions and education took place around this. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The practice demonstrated commitment to health promotion and education of patients regarding their health and encouraged the uptake of health screening programmes.
- Patients' satisfaction with the practice was high and patients reported they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. The National Patient Survey data published in July 2016 was also consistently high specifically regarding the caring aspects of the practice.

Summary of findings

- The practice had nominated a carers champion and was actively seeking to provide information to support carers.
- Information about services and how to complain was available in the practice leaflet and on the website and was easy to understand although this was not advertised in the waiting areas. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment, although making an appointment with a preferred GP required a longer wait. Urgent appointments were available the same day and several patients we spoke with had been accommodated on the day. The practice was also part of a pilot scheme providing access to GP appointments at weekends at a local centre.
- 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 and complied with the requirements of the duty of candour and had a policy providing guidance on this.

The areas where the provider should make improvement are:

- Continue to monitor the system re-established for managing safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Maintain an inventory of standard medicines kept in the practice.
- Continue to update policies and training in line with the practice plan.
- Ensure information about how to complain is displayed for patients to see.

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.

Good



- There was an effective system in place for reporting and recording significant events which all staff demonstrated an awareness of and learning was shared throughout the practice. We noted effective changes and outcomes as a result of investigation of significant events which had been shared with all staff.
- Lessons were shared to make sure action was taken to improve safety in the practice. For example, the practice had updated the computer template following a medication error to ensure all the correct information was available immediately and staff were made aware.
- When things went wrong patients received reasonable support, 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 in place to keep patients safe and safeguarded from abuse. For example, the practice had placed alerts on records of all family members in the household when a child was at risk to ensure staff were aware and enable them to observe for signs of problems and offer support where necessary.
- Risks to patients were assessed and well managed and whilst we noted the practice had a system for managing safety alerts in the past, the responsibility for this had not been transferred during changes in the practice management. However, the practice responded promptly and introduced a robust and appropriate system to address this and submitted evidence to demonstrate this. They carried out a retrospective audit and demonstrated that no patients had been put at risk.
- The practice had carried out an emergency scenario involving all staff in the practice to assess the effectiveness of their response following a review of their emergency equipment and procedures.

Are services effective?

The practice is rated as good for providing effective services.

Good



Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice had introduced a system to generate reminder letters when they became aware patients had not taken up screening.
- The practice had introduced screening for atrial fibrillation at the flu clinics for older patients.
- Clinical audits demonstrated quality improvement.
- The practice had a GP with a special interest in rheumatology and operated a rheumatology clinic. They initiated treatment and reviewed and monitored patients, providing appropriate bloods tests in line with shared care agreements with secondary care. This prevented patients having to attend hospital and provided care closer to home.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. Nurses and GPs were trained in specific areas which allowed them to carry out their roles effectively. For example, the nurses had been trained in asthma and diabetes.
- The GPs were committed to teaching and educating staff, medical students, trainee GPs and nurses and apprentices and provided teaching sessions and opportunities for learning both practical and theoretical.
- 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?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey published in July 2016 showed patients rated the practice higher than others for most aspects of care. Patients we spoke with and staff from other services commented on how they felt the practice offered over and above what was required of them and of the commitment of the practice to deliver patient centred care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.

Good



Summary of findings

We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality and patients reported that this was their experience of care received at the practice.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice provided an international normalised ratio (INR) clinic for their own patients and patients from other practices in the area to prevent them having to attend the local hospital. INR clinics provide monitoring of patients who require regular anticoagulation therapy (blood thinning).
- 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.
- Information about how to complain was available on the practice website and was easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. However, there was no information regarding how to complain displayed in the waiting area.

Are services well-led?

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

Good



- 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 practice meetings where governance was discussed.
- The partners had succession plans in place for impending retirements in the next few years.
- 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.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice offered screening for atrial fibrillation at flu clinics.

The practice participated in the 'Admission Avoidance' enhanced service and followed up patients at risk of admission to ensure their needs were being met.

Good



People with long term conditions

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice demonstrated positive achievements in monitoring patients with long term conditions. For example, the percentage of patients with diabetes, on the register, whose last measured total cholesterol was within the recommended acceptable level was 77% which was comparable to the CCG and national averages of 80% and 81% respectively.
- Longer appointments and home visits were available when needed.

All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. 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.

Good



Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations.

Good



Summary of findings

- The practice had good use of system alerts which identified all members of the family who lived in a household where there were children at risk.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Cervical screening rates were above the CCG and national averages. The percentage of females aged 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %) was 73% compared to the CCG and national averages of 67% and 74% respectively.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Child health medicals and post-natal checks were offered for new mothers as well as midwife appointments.
- We saw positive examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

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

- The needs of 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.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered HIV testing and INR testing to reduce the need of patients to attend hospital.
- The practice used macros to remind staff to invite patients to attend for screening for national programmes such as bowel and breast screening and data showed uptake was higher than the CCG and national rates.

Good



People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.

Good



Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients. There was access to councillors and alcohol misuse support.
- 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)

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

- 97% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was higher than the CCG average of 87% and national average 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 87% compared to the CCG and national averages of 91% and 88% respectively.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



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 above the local and national averages in all areas except, being able to see a preferred GP and waiting 15 minutes or less to be seen. There were 326 survey forms distributed and 121 were returned which represented over 1% of the practice's patient list and a response rate of 37%.

- 85% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group (CCG) average of 70% and the national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% national average of 85%.
- 92% of patients described their overall experience of this GP practice as good compared to the CCG average of 82% national average of 85%.

- 86% 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 75% national average of 78%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards, 34 of which were all positive about the standard of care received and two that contained comments regarding appointments running late and difficulty in booking appointments. We noted consistent comments regarding the GPs listening skills and high standard of care received and of the caring, friendly approach of all staff.

We spoke with seven patients during the inspection two of whom were members of the patient participation group. A patient participation group is a group of patients who represent the views of patients and work with the practice to improve services. All patients we spoke with said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service **SHOULD** take to improve

- Continue to monitor the system re-established for managing safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Maintain an inventory of standard medicines kept in the practice.
- Continue to update policies and training in line with the practice plan.
- Ensure information about how to complain is displayed for patients to see.

Wychall Lane Surgery

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 Wychall Lane Surgery

Wychall Lane Surgery is a GP practice which provides primary medical services under a General Medical Services (GMS) contract to a population of approximately 9,200 patients living in Kings Norton and surrounding areas of Birmingham. A GMS contract is a standard nationally agreed contract used for general medical services providers.

The practice operates from a spacious two storey building where consultations with patients only take place on the ground floor. There are disabled parking spaces and a ramp leading to the front door to allow access to the premises for patients with mobility difficulties and there is a bell to alert the reception for assistance.

The practice population has a higher than average number of patients aged 0 to 15 years, and slightly above average numbers for those aged 50 to 70 years. National data indicates that the area is one that experiences significant levels of deprivation. The practice population is made up of predominantly white British with pockets patients from ethnic minority groups.

There are seven GP partners, five female, and two male. The practice employ an honorary salaried female GP with a special interest in weight management, an advanced nurse

practitioner, two practice nurses, a treatment room nurse, a health care assistant, a practice manager and reception manager, who are supported by a team of administrative and reception staff.

Wychall Lane Surgery is an approved training practice for trainee GPs and supports medical students from Birmingham University. A trainee GP is a qualified doctor who is training to become a GP through a period of working and training in a practice. They also support nursing students and participate in an apprentice scheme. At the time of inspection the practice had three GP trainees. A GP trainee is a qualified doctor undergoing a period of further training in order to become a GP

The practice is open on Monday until Friday between 8am and 6.30pm and there is always access to a GP during these times. The telephones are switched over between 1pm and 2pm to allow for staff handover and calls are received by the out of hours service during that time but the practice remains open. Extended hours appointments are provided from 6.30pm until 7.30pm on Mondays, Tuesdays and Wednesdays for pre-bookable appointments only. When the surgery is closed services are provided by Badger who can be contacted via NHS 111.

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 201

Detailed findings

How we carried out this inspection

Before inspecting, 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 inspection on 2 September 2016. During our inspection we:

- Spoke with a range of staff including GPs, nurses, the practice manager, reception manager assistant reception manager, administration staff and spoke with patients who attended the practice that day.
- Observed how staff assisted patients who attended the practice and dealt with their queries.
- Reviewed an anonymised sample of the treatment records of patients.
- 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.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff we spoke with were all aware of the procedure for reporting significant events. They told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system which was updated as events were actioned. 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events and we noted how actions had been taken to share the information with all staff in the practice and measures implemented to prevent recurrence. For example, we saw how the practice had updated all staff in emergency resuscitation procedures and carried out an emergency scenario to assess if staff responded appropriately.
- We also saw evidence of a serious significant event where the practice had carried out extensive investigation and implemented robust arrangements to address all areas where learning had been identified. There had been a plan implemented which had been regularly discussed and updated.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We noted that the system for responding to Medicines and Healthcare products Regulatory Agency safety alerts (MHRA) had not been updated since the recent change in management and the transfer of responsibility for ensuring that alerts had been actioned had been overlooked. The practice told us that prescribing alerts were always discussed with the prescribing advisors who they met with regularly. The nurses told us that they had received MHRA alerts until recently and provided examples of alerts they had received but that did not require any

action. The practice responded immediately to this omission and developed a robust protocol for ensuring alerts had been responded to. The practice submitted evidence which demonstrated that the revised system was effective and they confirmed this had been shared with staff and implemented. The practice also carried out an audit which demonstrated that all alerts issued during the change in management had been addressed, confirming that no patients had been at risk.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements 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 GP for safeguarding and all GPs and the advanced nurse practitioner were trained to level three in child safeguarding and practice nurses to level two. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The practice recorded an alert on the records of all family members living in the same household as children on the child 'at risk' register. They also had alerts on the records of all vulnerable patients and worked closely with the local children's centre regarding children who were at risk. The practice had been involved in a pilot scheme regarding raising awareness of female genital mutilation (FGM) and staff had been received awareness training. We saw information posters in the seminar room alerting staff to this.

- There were notices in the treatment rooms advising patients that chaperones were available if required. All staff who acted as chaperones were trained for the role. Non-clinical staff had not received a Disclosure and Barring Service (DBS) check, but the practice had carried out a risk assessment which identified that patients would never to be left alone with chaperones. (DBS

Are services safe?

checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. We saw that an annual infection control audit had been undertaken and evidence that action had been taken to address any improvements identified as a result. The infection control lead had cleaning schedules for clinical items such as ear syringes, that required daily or weekly cleaning and we saw these had been completed appropriately. General cleaning of the practice was carried out by external contractors who had service specifications and this was audited monthly.
- 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). We noted the general medicines in the nurses room, whilst they were securely stored they did not keep an inventory of these. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We saw that the practice had a policy for dealing with patients' requests for high risk medicines and that patients and their blood tests had been monitored prior to prescribing. This included what actions should be taken in response to blood levels. The practice carried out regular medicines audits, with the support of the local CCG medicines management 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 in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow

nurses to administer medicines in line with legislation. The health care assistant was undergoing training to give flu vaccinations and was to be assessed by the nurses when training was complete.

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

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 room upstairs which identified the health and safety representative. We saw up to date fire risk assessments and the practice had carried out recent fire drills and had identified fire marshals. All electrical equipment had been checked in January 2016 to ensure the equipment was safe to use and clinical equipment was checked in November 2015 to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The Legionella assessment had been carried out by an external company and the practice had addressed areas identified for action and this was scheduled to be repeated in 2017.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had a staffing level assessment form which assisted the practice manager in ensuring there were appropriate levels of staff on duty during periods of additional workload such as the flu season.

Arrangements to deal with emergencies and major incidents

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

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in a specific room as well as medicines to treat anaphylaxis which were available in all treatment rooms and home visit bags. The practice had recently reviewed their emergency procedures and introduced a new policy which was to be reviewed six monthly. We noted that the practice did not include a specific medicine for potential use following a rare reaction to insertion of an intrauterine contraceptive device. The practice had carried out a risk assessment and had concluded they did not require this. We saw from minutes of meetings that the practice had discussed the emergency medicines and equipment and made assessments and decisions regarding what they should keep in stock. However, following our inspection they reviewed this decision and provided evidence to demonstrate this had been included in the emergency medicines and the policy updated to reflect this. All the medicines we

checked were in date and stored securely. This included fridge temperatures where vaccines were stored, which had been recorded appropriately and were within the required limits. The practice also had a data logger which the practice nurse checked weekly.

- The practice had recently identified an afternoon to facilitate a learning session and carried out a simulation of a medical emergency to determine how prepared staff felt to respond and identify any areas of learning and establish the effectiveness of their response. This involved staff at all levels and was reported to have been successful.
- 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. We noted the emergency procedures in place were robust.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice manager and partners kept a copy of the plan off site for use in an emergency.

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.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice had systems in place to keep all clinical staff up to date. For example, guidelines and updates were presented at clinical meetings and shared with all clinical staff. We noted some of the latest changes had been laminated and presented on a learning board for staff to refer to.
- 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 from 2014/15 showed the practice had achieved 95% of the total number of points available. One of the GPs was the lead for QOF and had two administration staff who supported them in this role to ensure focus was directed in areas which required attention. Other GPs in the practice were allocated specific clinical areas to oversee.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

Performance for diabetes related indicators was above the national average. For example, the percentage of patients with diabetes, on the register, in whom the last blood glucose recording was within the recommended acceptable limits in the preceding 12 months (01/04/2014 to 31/03/2015) was 82% compared with the CCG and national average of 77% and 78% respectively.

Performance for mental health related indicators was similar to the CCG and national averages. For example, the

percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 87% compared to the CCG and national averages of 91% and 87% respectively.

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits completed in the last two years, one of these was a completed audit where the improvements made were implemented and monitored. For example, patients with certain heart conditions were identified for six monthly reviews and alerts placed on the clinical system to ensure these were carried out. The other one was due for re-audit soon.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

Information about patients' outcomes was used to make improvements such as when a patient was identified as being unwell at a flu clinic, taking their pulse alerted staff that they may have had atrial fibrillation which was confirmed. As a result of this the practice decided to carry out routine screening in older patients for this condition during flu clinics.

One of the GPs had a special interest in rheumatology and operated a rheumatology clinic assisted by one the practice nurses. They initiated treatment and reviewed and monitored patients, providing appropriate bloods test in line with shared care agreements with secondary care. This prevented patients having to attend hospital and provided care closer to home.

Effective staffing

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

- The practice had a recruitment policy and induction programme for all newly appointed staff. The practice manager was updating their checklist to include topics such as 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 that the nursing staff had been trained in long term conditions such as diabetes and

Are services effective?

(for example, treatment is effective)

asthma and received update training. The nurses attended a practice nurse respiratory group led by the specialist respiratory nurse who organised guest speakers such as consultants in both adult and paediatric asthma.

- 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, mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- 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.
- The practice demonstrated a genuine commitment to teaching, development and learning and invested time and provided significant support to both medical students, trainee GPs and nurses. Trainees and staff spoke highly of the support and teaching they had always received from the practice. One of the GPs was a Training Programme Director and three of the other partners were GP trainers.

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 use of the macros developed prompted staff to access additional information and assisted in clinical decision making and supported clinical coding to allow accurate recording of information.

- 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. 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. We saw evidence of multi-disciplinary meetings with the palliative care team, and safeguarding meetings.

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 (MCA). One of the GPs had delivered a presentation to staff regarding the MCA in November 2015 to raise awareness.
- 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.
- We saw the practice consent form which was used for minor surgery and contraceptive implants and intra uterine device insertions. This was appropriate and scanned into the patients' records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation, transgender patients and veterans. Patients were signposted to the relevant services.

Are services effective?

(for example, treatment is effective)

- The practice had an honorary salaried GP with a special interest in weight management who was developing work with this group of patients to achieve better outcomes. The practice had identified a group of 776 patients registered as obese who may benefit from this work.
- The practice was involved in a pilot scheme to educate patients who had been identified as pre-diabetic. They hosted sessions led by Health Trainers who worked with this group of patients to reduce their risk of developing diabetes.
- In addition to the above pilot scheme the practice also followed up patients who had experience gestational diabetes following delivery of their baby.

Screening for HIV was offered at the practice. Two years ago they also introduced screening for atrial fibrillation for older patients when they attended the flu clinic and patients were referred to specialist care when required.

The practice's uptake for the cervical screening programme was 73%, which was higher than the CCG average of 67% and comparable with the national average of 74%. 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 ensuring a female sample taker was available. The nurses demonstrated how they had failsafe systems in place 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 had a proactive approach to national screening programmes such as for breast and bowel screening. One of the GPs with an interest in information technology (IT) had developed and introduced a system which directed staff to send out letters if screening was outstanding. This system had been introduced for a wide range of areas of health promotion. We noted the patient uptake for bowel and breast screening was higher than the CCG average. For example:

- the percentage of females aged 50-70, screened for breast cancer in last 36 months (3 year coverage, %) was 72% compared to the CCG average of 65%.
- the percentage of patients aged 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) was 54% compared with the CCG average of 46%.

Childhood immunisation rates for the vaccinations given were higher than the CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 80% to 99% compared to the CCG average of 79% to 96% and five year olds from 86% to 98% compared to the CCG average of 84% to 95%.

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 years. 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 members of staff were courteous and very helpful to patients and treated them with dignity and respect. Staff provided appropriate assistance to patients attending the reception desk and conversations we heard demonstrated kindness and consideration.

- 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 and conversations taking place in these rooms could not be overheard.
- We saw a notice on the reception desk advising patients to inform reception staff if they wished to discuss anything in private and a room would be arranged. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

There were 36 patient Care Quality Commission comment cards received. Thirty four of these reported complete satisfaction about the service experienced, with patients consistently commenting on the high standard of care they received and reference to specific GPs and their listening skills and how they treated patients compassionately. There were references to how GPs and staff had specific regard to younger patients and had dealt with them sensitively providing information and guidance. We also spoke with young patients during our inspection who also reported the GPs explained their condition and treatment and ensured they had understood. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We noted that the practice had included leaflets and information for young carers as part of carers information.

We spoke with two members of the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. 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 reception staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 97% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 91% 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 91%.
- 94% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

We noted there was a sign in reception advising patients if they felt unwell to notify the reception staff.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us they felt involved in decision making about the care and treatment they received and that both GPs and nurses took time to explain their conditions and the treatment required. 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.

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 consistently above the local and national averages. For example:

Are services caring?

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 88% 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% and the national average of 85%.
- 89% 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% national average of 85%.
- 94% of patients reported finding reception staff helpful, compared to the CCG and national averages of 86% and 87% respectively.
- 97% of patients reported the GP gave them enough time compared to the CCG and national averages of 86% and 87% respectively.

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 and some of the GPs spoke additional languages.
- There was a hearing loop available to assist patients with a hearing impairment.
- There was a comprehensive selection of information leaflets available in easy read format and the practice also printed off the most up to date condition specific information if they needed to.

We noted that the practice displayed a 'Network Award' which had been awarded to a colleague who had shown commitment to local priorities and helped to translate them.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the waiting area which told patients how to access a

number of support groups and organisations. We saw information regarding memory clinics, pulmonary rehabilitation, Age Concern and Alzheimer's support. There were also designated notice boards promoting carers support and support and resources for patients experiencing mental health problems.

Patients we spoke with suffering with long term conditions expressed the benefits they had experienced from the support provided by the GPs and nurses to understand and live with their conditions. We saw testimonies from other health care agencies reporting how the practice had always responded promptly and appropriately to patients in the end of life phase and provided support and assistance to both patients and other staff caring for them. We also received positive feedback from a local care home where the practice provided services. They reported receiving good support from the practice and found the practice responsive and caring, providing explanation and reassurance to patients regarding their care and treatment.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 263 patients as carers which represents just under 3% of the practice list. The practice had identified a member of the administration team as the 'Carers Champion'. They told us they had been contacting organisations to obtain information and compiled information packs for carers. We saw that these also contained information for young carers. This work was in its infancy and the staff involved spoke enthusiastically about this role. The GPs were entering information on the computer system to identify carers as their status became known to them opportunistically to enable them to be offered flu vaccines and information on support available.

Staff told us that if families had suffered bereavement, the practice sent a letter of condolence and offered further support.

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 had participated in a local pilot scheme for seven day access to GP services. They also provided an international normalised ratio (INR) clinic for their own patients and patients from other practices in the area to prevent them having to attend the local hospital. INR clinics provide monitoring of patients who require regular anticoagulation therapy to prevent blood from clotting

- The practice offered extended hours appointments for working patients and those 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.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. This was achieved by telephone triage when a GP would call the patient and assess whether they needed to be seen that day. They also had a nurse practitioner who could deal with types of urgent care.
- Patients were able to receive travel vaccinations available on the NHS.
- There were disabled facilities, a hearing loop and translation services available.
- The practice offered a range of services including sexual health and contraception, rheumatology clinic, substance misuse, joint injections and minor surgery.
- The practice also hosted various services for patients to access, such as the midwife, health trainers, the drug and alcohol misuse service, and counselling service.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday and there was always access to a GP during these times. The telephones were switched over between 1pm and 2pm to allow for staff handover and calls were received by the out of hours service during that time but the practice remained open. Extended hours appointments were

offered on a Monday, Tuesday and Wednesday evening from 6.30 until 7.30pm. 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 on the day. The practice had introduced a GP triage system to enable patients to speak with a GP to determine if they needed to be seen on the day.

Results from the National GP Patient Survey showed that patients' satisfaction with how they could access care and treatment was above the local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 85% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. Several patients we spoke with had called that morning and one patient commented on the rapid response to their health problem and how the practice had initiated appropriate tests immediately.

The practice had a system in place to assess whether a home visit was clinically necessary. There was a triage GP who was available to decide on the urgency of the need for medical attention.

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 an effective system in place for handling complaints and concerns. This was advertised on the practice website and also in the practice leaflet, although there was no information in the waiting area regarding how to complain other than a poster with information concerning the advocacy service.

- The practice 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 and

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

shared the outcomes of investigation of these with the GPs and staff in the practice. Staff we spoke with confirmed that they were kept informed of outcomes of complaints.

We looked at a summary of all the complaints received in the last 12 months and found and followed an example through in detail. We found that they had been thoroughly investigated in a timely way with openness and

transparency. We saw that the practice had taken appropriate actions where they had identified improvements. The practice manager logged complaints to demonstrate actions taken and how the learning had been implemented. For example, they had implemented the wearing of identification badges by staff in response to concerns from patients. The use of this log allowed the practice to identify if there were any trends evident.

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 GPs encouraged a compassionate and caring ethos throughout the practice. We saw evidence of good communication of the vision and values of the practice both from discussions with staff and from observations we made. The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored and we noted they met weekly to discuss all aspects of development of the practice. There was a strong emphasis on education, teaching, supporting and developing staff and other learners to promote good care. The practice had plans in place for impending retirements over the next two years and was planning training of specific clinicians in areas where there could be gaps in expertise in the future.

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. For example, one of the GPs had the lead role for QOF and was supported by administration staff.
- Practice specific policies were implemented and were available to all staff. The new practice manager was updating these and was working through them systematically.
- A comprehensive understanding of the performance of the practice was maintained. We noted from minutes of meetings and discussions with staff that this was discussed regularly and areas which required focus were addressed.
- There was evidence of clinical and internal audit which was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, although we noted one area which had been

overlooked since the change of practice manager. However, the practice addressed this immediately and put measures in place, following discussion with partners and development of new protocols.

Leadership and culture

The partners in the practice demonstrated good communication and that 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 and we saw several examples where they had addressed potential risks. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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). The practice had a policy regarding the duty of candour policy which they had recently updated. 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, 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 in place and staff felt supported by management.

- Staff told us the practice held regular team meetings and we saw minutes of the meetings to confirm this.
- 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.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the services delivered by the practice. The nurses gave examples of changes that were implemented following their

Are services well-led?

Good 

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

suggestions and discussions with the GPs to enhance patient care. For example, the introduction of a vaccine porter to allow better transportation of vaccines to housebound patients.

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 an active patient participation group (PPG) which met quarterly and provided feedback to the practice regarding the service provided. We spoke with two members of the PPG who reported that the practice worked well with the group and listened and acted on their views and comments. They told us they felt valued and were pro-active in gaining views from patients. The practice was always represented by one of the GPs and the practice manager who could respond to any issues from the PPG. For example, the PPG expressed dissatisfaction at being placed on hold on the telephone when patients arrived at the reception desk. As a result the practice stopped the reception staff answering the telephone at reception and transferred these duties to staff in the back of reception. They had subsequently made plans to move telephones for appointments to another room upstairs in the practice. They told us of the significant changes that had taken place in the previous three years and how they had worked together to improve the practice. For example, they had introduced a 'Healthy Minds Notice Board' to alert patients to mental health services. They were also introducing a practice newsletter and intended to include areas of NHS focus to inform patients. The

practice was supporting the PPG in the introduction of this. They were also exploring the possibility of inviting guest speakers to provide health talks. The PPG members expressed high levels of satisfaction with the staff at the practice.

- The practice had gathered feedback from staff through staff meetings, appraisals and general discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Several of the staff had been employed at the practice for many years and all staff we spoke with told us they felt valued, involved and engaged with the practice in how to improve it.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The GPs were committed to teaching and training GPs and medical students as well as nursing students and apprentices. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, they had become involved with the Challenge Fund which allowed access to GP appointments at another venue out of hours. This was for a trial period which was still in progress.

The practice had an honorary salaried GP with a special interest in weight management. They were setting up services to identify and provide support for patients who were obese. The practice had also recently employed an advanced nurse practitioner and treatment room nurse following a review of the needs of the practice which allowed a better skill mix and improved access to services. Two of the GPs had recently completed a six module leadership course.