King Edward Road Surgery

Quality Report

Christchurch Medical Centre
King Edward Road
Northampton
NN1 5LY
Tel: 01604611600
Website: www.kers.org.uk

Date of inspection visit: 28 August 2015
Date of publication: 22/10/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at King Edward Road Surgery on 28 August 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice had developed and implemented good systems using information technology which enabled sharing of information regarding planning and patient care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice facilities were well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision with an emphasis on quality and safety. An improvement plan was in place, which we saw was reviewed and discussed with all staff at protected learning sessions. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Summary of findings

However there was an area of practice where the provider should make improvements:

- Consider formally revisiting the outcomes following actions implemented after significant events to determine the effectiveness of the measures put in place.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice had identified safety as a high priority and had implemented systems and processes to help keep patients safe by the use of information technology and involvement of all staff. Procedures specifically benefitted those patients who were vulnerable and those who had mental health problems. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice learned from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive and recognised as the responsibility of all staff.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

appointments available the same day. The practice facilities were well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with input from staff and was reviewed and discussed with them. Safety for patients, specifically the vulnerable and those with mental health problems was a high priority for the practice which had been shared with all staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had an active patient participation group (PPG) which influenced practice development.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice had systems in place to highlight the specific needs of this group of patient and ensure that information was recorded and shared with the correct staff providing care. In addition nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice was 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 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, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice was 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 and flexible. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. They had good systems in place to identify, review and follow up vulnerable patients if they do not attend and regular communication with social services and other members of the primary health care team. They also had put measures in place to ensure that people at the end of their life had access to the correct medication without delay. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability. They had access to translation facilities and also had doctors who spoke Urdu and Punjabi.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). They had robust systems of identifying this group of patients and ways of ensuring they were followed up appropriately if they did not attend for treatment. There were also systems in place to monitor medications and tests required prior to prescribing. They provided specific care to homes with vulnerable patients and ensured that the appropriate tests and procedures took place in the best interest of patients. They were proactive in seeking out patients suffering with dementia in order to ensure they received the correct care and treatment. Annual physical health checks were carried out and the practice accessed support from appropriate mental health teams in a timely way and ensured good communication with them and patients. They worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and there was a GP with additional training in psychiatry.

Summary of findings

What people who use the service say

We looked at the national GP patient survey results published in July 2015 for the most recent data. This showed the practice was performing in line with or below local and national averages in some areas regarding access to the service and involvement in decisions around care, but above average in some areas concerning treatment by nursing staff. There were 91 responses and a response rate of 33%.

- 52% find it easy to get through to this surgery by phone compared with a CCG average of 71% and a national average of 73%.
- 82% find the receptionists at this surgery helpful compared with a CCG average of 85% and a national average of 87%.
- 21% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 55% and a national average of 60%.
- 78% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 85% and a national average of 85%.
- 95% say the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 70% describe their experience of making an appointment as good compared with a CCG average of 72% and a national average of 73%.
- 65% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 67% and a national average of 65%.
- 55% feel they don't normally have to wait too long to be seen compared with a CCG average of 59% and a national average of 58%.

We also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards. Thirty-seven of these were positive about the standard of care received and four referred to difficulty in getting appointments by phone . Patients commented on the high standard of care received and mentioned specific members of staff by name, highlighting examples of good care in times of specific health difficulties where additional support and understanding was provided. Comments referred to being treated with dignity, kindness and compassion, being referred appropriately and promptly for specialist care and guided to appropriate support groups when required.

We also spoke with 12 patients, six of whom were members of the patient participation group. Patients we spoke with were also positive regarding the care received from the GPs and nurses and whilst two mentioned that getting through on the telephone could be challenging at times, they commented that this seemed to have improved in recent months.

Areas for improvement

Action the service SHOULD take to improve

- Consider formally revisiting the outcomes following actions implemented after significant events to determine the effectiveness of the measures put in place.

King Edward Road 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, a practice manager specialist adviser and another CQC inspector.

Background to King Edward Road Surgery

King Edward Road surgery provides general medical services to a population of approximately 11,200 patients in Northampton town centre and surrounding areas under a general medical services (GMS) contract. The practice population had a higher than average number of patients aged 0 to 5 years and 25 to 50 years and national data indicates that the area does not have high levels of deprivation.

The practice has six GP partners, three full time male and three part time female. They employ four nurses, three of whom are nurse prescribers, and a health care assistant. There is a practice manager and assistant practice manager who are supported by a team of administration and reception staff. It is a training practice and which trains and supports doctors who are qualified and who are training to be GPs as well as newly qualified doctors gaining experience in general practice and medical students.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are available on Thursdays from 6.30pm until 8.30pm and Saturday mornings from 7.45am until 11am for pre-booked appointments only. When the surgery is closed services are provided by Integrated Care 24 Limited and patients can contact the service via NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before inspecting the practice we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 28 August 2015.

During our inspection we spoke with a range of staff, including GPs, nurses, the health care assistant, reception and administration staff and we spoke with patients who used the service including members of the patient participation group. We observed how patients were assisted by staff when attending the practice and looked at staff records and policies and procedures in operation at the practice. We also reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

We saw evidence that safety had been given a high priority in the practice by clinical staff with involvement and support from administrative and reception staff. They had developed robust recording and monitoring systems and templates which linked into patient records to ensure that all information was recorded immediately and was available to all staff at all times. The practice demonstrated the system in place for significant events and we saw that people affected by significant events received a timely and sincere apology and were told about actions taken to improve care. All staff had access to the reporting system and they told us they would inform the practice manager of any incidents. There was also a recording form available on the practice's computer system. This form linked directly into the patient records and all staff could see a full account of what had occurred if a significant event had affected a specific patient. There was an open and transparent approach and a system in place for reporting and recording significant events. We saw evidence that the practice had used the significant events process and made changes in systems and procedures to improve the safety to patients in the practice.

All complaints received by the practice were entered onto the system and dealt with appropriately and learning shared. The practice carried out an analysis of the significant events and investigated them all thoroughly and addressed any issues to prevent recurrence. We noted that the practice did not formally revisit the outcomes to determine the effectiveness of the measures put in place.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw a change in the system when a patient had not been called for their treatment in a timely way and that this had been shared with all the team.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. We saw that the reporting of safety incidents to the National Reporting and Learning System (NRLS) had been discussed at a locality prescribing meeting and the introduction of a new eForm had been shared with the practice locality lead for use in the practice as this was a new system to make reporting of safety incidents quicker and easier. These safety systems enabled staff to understand risks and gave a clear, accurate and current picture of safety. The lead nurse was responsible for dealing with and taking actions required from safety alerts and we saw a robust system in place for recording actions to demonstrate they had been dealt with appropriately.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding and the practice held separate multi-disciplinary meetings for children and adults to discuss safeguarding issues for patients who were at risk. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. We saw minutes where vulnerable adults and children had been discussed and how patients were highlighted as vulnerable and why. We also saw evidence of communication with the safeguarding teams.

We saw a wide range of systems which had been developed by the practice to improve safety and information sharing. The practice had implemented a system which required reception staff to input an alert on screen when a vulnerable patient made an appointment so that if they did not attend the GP would follow them up. They had also introduced 'at risk' icons which linked to the patients care plan which included consent to contact them. We saw that all staff were aware of these systems and used them and the practice had specific staff who had developed the templates to improve safety in the practice. We also saw that the systems allowed information from care plans to be imported into spread sheets which were shared at multidisciplinary team meetings.

The practice cared for over 200 patients in care homes and had introduced a care home template to prompt staff to carry out screening for dementia and complete care plans for patients with complex care needs, which were accessible during consultations. We saw from looking at care plans how this had allowed the care team to share the

events of the patients' care and allow a thorough holistic assessment of their needs. The systems in place clearly identified 154 vulnerable patients on a register who had an 'at risk' icon which was linked to a care plan and consent to contact them.The systems also had an icon that identified the 130 patients who were taking high risk medicines and had allowed the practice to audit and identify 11 patients who had not attended and were due blood tests. The icon also linked to show what action to take if their test was abnormal and the patient could be notified by SMS from the linked template.

The practice had also introduced procedures to ensure that anticipatory medicines were prescribed with appropriate directions so they could be used immediately when required by patients at the end of their life, preventing any delays.Anticipatory medicines are prescribed medicines such as strong pain relief that are kept by the patient to be administered by a doctor or a nurse 'just in case'.

- A notice was displayed on all consulting room doors, advising patients that a chaperone was available if required. All staff who acted as chaperones were trained for the role. We saw a risk assessment had been carried out which stated that non-clinical staff who had not had a DBS would not be left alone with patients. A chaperone policy was also available for staff to refer to. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control nurse who worked closely with one of the GPs who had also been identified as lead GP for infection control. The nurse liaised with the local infection prevention nurse to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken and reviewed every three months and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The prescribing advisor was located at the practice which promoted improved communication regarding medicines management. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises which was shared with the other practice in the building. There was a clear, robust system which showed who was responsible for checking this. Oxygen with adult and children's masks were available if necessary. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

Good

Are services safe?

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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. They had systems in place to ensure all clinical staff were kept up to date. For example, NICE guidance was incorporated into templates for chronic disease management and used widely in consultations. The practice had access to guidelines from NICE from Pathfinder which was a locally agreed set of pathways for the locality. They used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through audits and random sample checks of patient records. We also noted that new guidelines had been discussed at a team meeting when they had reviewed their referrals to specialist care. Discussions with GPs demonstrated that one of the GPs attended the local home for patients suffering with effects of severe head injury and had carried out end of life planning, mental capacity assessments and requested a 'best interest decision' meeting prior to implementing a 'do not attempt resuscitation' form.

The practice had actively sought out patients with dementia utilising audit and specific dementia screening tools and as a result had a dementia diagnosis rate of 78.7% compared to the national average of 62%

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework(QOF). (This is a system intended to improve the quality of general practice and reward good practice). They used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 99.7% of the total number of points available, with 16.2% exception reporting. Exception reporting relates to patients on a specific clinical register who can be excluded from individual QOF indicators. For example, if a patient is unsuitable for treatment, is newly registered with the practice or is newly diagnosed with a condition. This practice was not an outlier for any QOF (or other national) clinical targets. The practice had a monthly meeting of the staff responsible for specific areas of QOF to focus and ensure their high achievement in all areas continued.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been many clinical audits completed in the last two years, for example on near patient testing, contraception, bowel screening uptake and prescribing. Several of these were completed audits where improvements were implemented and monitored. Near patient testing is an investigation taken at the time of the consultation with instant availability of results to make immediate and informed decisions about patient care.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. One of the GPs had undertaken a quality improvement project in diabetes diagnosis which had resulted in heightened awareness of appropriate questions to ask patients prior to diagnosis. Learning from this was presented to the rest of the staff in the practice. We saw that the practice had created a plan for improvement and had identified specific areas where they wanted to improve outcomes for patients and specified how they would achieve these. For example, areas such as improving communication with the school nursing team, raising staff awareness of domestic abuse and monthly drop in clinics for young people.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. We spoke to a recently appointed member of staff who told us they had received an induction with a significant amount of training, support and supervision. They showed us evidence of their training undertaken to equip them to carry out their role and the continuous assessment until their mentor was assured of their competencies. We noted that this process had enabled the staff member to achieve the skills to carry out their role with confidence.

Good

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had received regular appraisal. Staff we spoke with showed us evidence of their training and ongoing learning and told us they were well supported in their role.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. They had access to and made use of e-learning training modules and in-house training and protected learning sessions.

Coordinating patient care and information sharing

The practice had good systems and templates which provided the information needed to plan and deliver care and treatment. This was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a weekly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. We saw examples where this had been implemented and noted that the practice discussed MCA and deprivation of living (DOLs) at weekly meetings to ensure all staff were up to date and knew how to deal with these. One of the GPs carried out teaching sessions at the practice to ensure trainees fully understood DOLs. We saw the practice's consent documentation for minor surgery which was signed and scanned into the patients records.

Health promotion and prevention

The practice had good systems to identify patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers and those at risk of developing a long-term condition. The practice was a yellow fever centre offering vaccination from specially trained staff and ensuring the appropriate communication with their own GP. The practice also carried out searches where practice prevalence was lower than average to identify unmet needs such as chronic obstructive pulmonary disease. Patients who may be in need of extra support were also identified by the practice.

The practice had a comprehensive screening programme. Their uptake for the cervical screening programme was 92.5%, which was higher than the CCG average of 81.4% and the national average of 81.7%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93.9% to 97.3% and five year olds from 93.8% to 96.2%. Flu vaccination rates for the over 65s were 68.2%, and at risk groups 40.9%. These were also slightly below the national averages of 73.2% and 52.2% respectively.

The practice also offered the C-Card facility which allows young people to access barrier methods of contraception without the need for an appointment. Young people aged 15 to 24 years could also access chlamydia screening.

Good

Are services effective?

(for example, treatment is effective)

The practice hosted sessions from the Well Being Team offering specific support for patients needing psychological support and the Primary Care Mental Health Liaison worker was also based at the practice allowing easier access to mental health support.

The practice had a blood pressure monitor in the reception area for patients to record their own blood pressure which was recorded in their records and any abnormality was followed up. The practice had plans in place to introduce NHS health checks for people aged 40–74 in the next few months following our inspection.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed that the GPs and other members of staff were courteous and very helpful to patients when attending the reception desk, on the telephone and when being called into their appointment by the GP or nurse. Patients were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The reception area had a demarcation line to encourage patients to stay back from the desk whilst the patient in front was being attended to which helped to maintain privacy. Staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 41 patient CQC comment cards we received were positive about the care received, although some expressed difficulty in getting an appointment by phone. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with six members of the patient participation group (PPG) on the day of our inspection. They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey 2015 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice satisfaction scores on consultations with doctors and nurses were similar to the CCG and national averages. For example:

- 85% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 83% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%
- 80% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 90% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Several patients gave specific examples of how the GP had explained their treatment options and explained best practice recommendations but that they had decided not to accept the treatments, and their views and decisions had been respected by the GPs. Other patients gave examples of where the GPs had listened to their preferred treatments and had carried out additional research into it to ensure it was appropriate and could be approved. Patients told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about how they were informed about tests and treatments. Results from the national patient survey showed:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 72% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw that the touch screen check in also had options in other languages.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and information leaflets and carers support numbers were provided to patients who were identified. Written information was also available in the waiting areas for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and patients were signposted to support groups such as CRUSE (which offered bereavement support) where appropriate. One of the GPs was trained in psychiatry and told us this was beneficial in supporting bereaved families. Patients that the practice knew were at the end of their life were discussed at multi-disciplinary meetings to ensure that their wishes for their preferred place of death were known to everyone involved in their care and this was recorded in their records.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, one of the GPs was the lead for the locality board and attended monthly meetings and would feedback to the practice areas of focus for the locality so that the practice could address these. The practice also held twice weekly referral meetings to discuss their referrals, hospital clinics and discharge letters to determine if the appropriate course of action had been taken and provide an opportunity to learn. The CCG prescribing adviser was located in the practice and they met regularly with them to identify any prescribing issues.

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

- The practice offered extended hours appointments on Thursdays from 6.30pm until 8.30pm and Saturday morning for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with mental health needs and a system in place for the GP to follow up any patients who did not attend.
- Home visits were available for older patients and any patients who would benefit from these. They also provided twice weekly visits to specific care home to ensure their needs were being met.
- Urgent access appointments were available for children and any patients who needed to see a GP urgently.
- There were disabled facilities, hearing loop and translation services available as well as a lift for patients seeing the GPs and the midwife on the first floor and ample space to manoeuvre pushchairs and mobility aids.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were available on Thursdays from 6.30pm until 8.30pm and Saturday mornings from 7.45am until 11am to provide appointments for those people who could not attend during normal hours. In addition to pre-bookable appointments that could be booked up to one and four weeks in advance, there were also appointments bookable on the day, as well as urgent appointments for people that needed them. Appointments were bookable online, by telephone and at the reception desk.

Although survey results showed telephone access was below the CCG and national average, patients we spoke with during our inspection told us it had improved recently. The practice had also made various changes to the telephone system to address this. 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 with the exception of the telephone access.

For example:

- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 57% of patients said they could get through easily to the surgery by phone compared to the CCG average of 71% and national average of 73%.
- 70% of patients described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73%.
- 65% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 67% and national average of 65%.

All patients we spoke with told us if they needed to see a GP urgently then they could.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice and there was also a GP lead for complaints of a clinical nature.

We saw that information was available to help patients understand the complaints system on the practice TV advertising screen as well as posters displayed in the practice. The procedure was also set out clearly on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at a selection of complaints received in the last 12 months and found they were all satisfactorily handled and dealt with in a timely way. There was openness and transparency with dealing with the complainant.

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care.

For example, we saw additional training identified for reception staff in handling test results. We also saw the practice had reviewed complaints annually to identify trends and as a result had noted that access and prescribing were the main issues and had taken steps to address these.

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 recently developed a new mission statement which they had included all of the staff in producing. Staff we spoke with confirmed this and we saw this was available in the practice and on the practice website. The practice had a strategy and supporting plans which reflected the vision and values and were monitored at the monthly partners meetings.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice through sharing QOF achievement and areas of focus such as long term conditions.
- A programme of continuous 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

Leadership, openness and transparency

During our inspection the partners demonstrated that the need to ensure high quality care and effective systems to enable this was a priority. We saw evidence that they prioritised safe, high quality and compassionate care and we saw many examples where they had identified the need to develop, and improve areas, such as safety. We saw how leadership and involvement of the whole team had facilitated change and improved systems in the practice. For example, the implementation of information technology systems and templates to alert all staff and promote safety for patients in the practice, specifically those whose circumstances made them vulnerable and those patients suffering from poor mental health. The GP partners had taken steps to develop a vision for the practice which included all staff suggestions in order to ensure commitment and embed safety and efficiency in the practice and better outcomes for patients as a priority. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. They told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings or any other time and felt confident to do this and felt supported if they did. The nursing team had a specific lead nurse who was supported by the GPs and in turn mentored and led the nursing team with clear direction, promoting high standards of care.

The team had regular protected learning sessions which provided an opportunity for staff to discuss best practice and develop improved ways of delivering care. Staff said they felt respected, valued and supported, particularly by the partners and lead nurse 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 they delivered.

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

The practice proactively gained patients' feedback and engaged patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG was a long standing and active group who met on a regular basis and the practice encouraged, valued and acted on the feedback from them. The PPG attended the practice monthly and carried out their own patient survey to continually gain an up to date view of what was important to patients. They also raised awareness of the work that took place in the practice and what services were available to them. This was further re-enforced by the PPG newsletter which was produced four times throughout the year. The PPG meetings were attended by one of the GPs for the first hour and the practice manager for the whole meeting who updated the group on events occurring in the practice. The PPG told us they felt that listened to and valued. They had worked with

Are services well-led?

Good

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

the practice to organise health education sessions for patients which had been well attended for conditions such as chronic obstructive airways disease (COPD), diabetes, obesity and dementia.

We spoke with six members of the PPG who told us the practice was very responsive to their suggestions and gave examples of where they had implemented change as a result of feedback from them. For example, there was much discussion regarding feedback from patients experiencing difficulty getting appointments. As a result, the practice introduced telephone triage. The practice were also responding to patients expressing difficulty in seeing a preferred GP and were trialling a waiting list to see a specific GP for non-urgent appointments. This meant that patients who did not mind waiting could put their name on a waiting list for a specific doctor and when an appointment became available they would be contacted.

The practice had also gathered feedback from staff through staff meetings, appraisals and general discussion that took place on a daily basis. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The GPs were committed to education and training and worked well and consistently with the locality teams and other community teams to promote good care and practice. They had GPs with special interests in a variety of areas, such as enhanced cardiology, dermatology and ear, nose and throat, and were working to offer more specialist services closer to home and prevent referral to hospital.