Westside Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Requires Improvement overall. We previously carried out an announced comprehensive inspection on 30 November 2016; the practice was rated inadequate, with the safe, effective and well-led key questions rates as inadequate. The practice was rated as requires improvement in responsive and good in caring. We found three breaches of the legal requirements and as a result we issued a warning notice in relation to:

- Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 – Safe Care and Treatment.
- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 – Good Governance.

In addition, we issued a requirement notice in relation to:

- Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 – Fit and Proper Persons Employed.

Following that inspection, the practice was placed in special measures.

We carried out an announced comprehensive inspection at Westside Surgery on 15 November 2017 to monitor that the necessary improvements had been made.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Requires Improvement

Are services responsive? – Requires Improvement

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The practice overall rating was requires improvement and this related to patients in each of the population groups:

Older People – Requires Improvement

People with long-term conditions – Requires Improvement

Families, children and young people – Requires Improvement

Working age people (including those recently retired and students) – Requires Improvement

People whose circumstances may make them vulnerable – Requires Improvement

People experiencing poor mental health (including people with dementia) - Requires Improvement

At this inspection we found:

Summary of findings

- The practice had systems, processes and practices in place to protect people from potential abuse. Staff were aware of how to raise a safeguarding concern and had access to internal leads and contacts for external safeguarding agencies.
- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- There were systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The partners had reviewed and increased its workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of patients and the demand for access to appointments.
- Staff had received essential training to enable them to carry out their duties safely.
- We saw that staff involved and treated patients with compassion, kindness, dignity and respect. However, the national patient survey highlighted that patient satisfaction scores were below local and national averages when asked about their feedback on GP consultations.
- Patient feedback on same day access to appointments was positive. However, some patients found it difficult to access the practice by telephone.
- The practice had suitable facilities was well equipped and maintained to treat patients and meet their needs.
- The practice worked proactively with the patient participation group (PPG) to meet the needs of their patients and had consulted with them and members of the community about a planned merger with a neighbouring GP practice based in the same building.
- There was a focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Consider how exception reporting can be reduced or better recorded to increase assurance that treatment given away from the practice has been appropriate and effective.
- Take steps to improve the uptake of health checks for those patients over 75 years.
- Explore how the patient satisfaction scores in relation to consultations with a GP from the National Patient Survey can be improved.
- Improve the complaints management by recording discussions held in practice meetings and updating the contact details on the practice website.
- GPs to adopt all policies including those relating to administration.
- Further follow good practice guidance and adopt control measures to make sure the risks to patients, staff and visitors are minimised.

I have taken this practice out of special measures. This recognises the significant improvements made to the quality of care provided by the service.

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

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

Westside 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 advisor and a practice manager advisor.

Background to Westside Surgery

Westside Surgery is located in Boston, Lincolnshire and delivers regulated activities from Westside Surgery only. Services provided by the practice are commissioned by Lincolnshire East Clinical Commissioning Group (LECCG).

The practice is registered with the Care Quality Commission (CQC) as a partnership provider and holds a General Medical Services (GMS) contract with NHS England and provides a number of enhanced services to include minor surgery. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice treats patients of all ages and provides a range of medical services. There are currently around 10,280 registered patients at the practice. The practice local area has pockets of deprivation and a transient population which swells in the summer due to the influx of temporary agricultural workers. The practice has a slightly higher percentage of patients aged 18 and under, and a slightly lower percentage of patients aged 65 and over compared to the national averages. The practice has 57% of patients with a long-standing health condition compared to the CCG average of 61% and the national average of 53%. The practice has a high percentage of Eastern European foreign nationals as patients, mainly Polish, which fluctuates during the year but is approximately 16% of the patient list.

The practice operates from a purpose built, privately owned building shared with another GP Practice. The practice is owned and managed by a team of four GP partners who are supported by locum GPs, an advanced nurse practitioner (ANP), a clinical associate, four practice nurses, three healthcare assistants, an administration team and a management team. The practice had a GP registrar working and training under the supervision of the senior GP. Opening hours are between 8am and 6.30pm Monday to Friday. Extended hours appointments are available on Monday and Thursday evenings from 6.30pm to 8pm aimed at, but not exclusively for patients who would otherwise find it difficult to attend the practice during the day due to work or unforeseen circumstances.

The practice is an approved training practice for the training of General Practice Registrars and medical students; and currently has one trainee GP. The practice is registered with a local university and works with them on research projects which aim to improve future patient care. The practice is also a member of the Community Educators Providers Network (CEPN) and provides placements for undergraduate medical students and nursing students. In addition, work experience placements are provided to non-clinical staff and the practice participates in an apprenticeship scheme.

Additional information about the practice is available on their website: www.westsidesurgery.uk

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies that included the most recent definitions of abuse were reviewed annually and were accessible to all staff. Staff knew how to identify and report safeguarding concerns and had access to internal leads and contacts for external safeguarding agencies. Staff shared two examples of reporting safeguarding concerns and worked with other agencies to support patients and protect them from neglect and abuse. Safeguarding concerns were considered and documented from when children had not attended secondary care, but the policy did not state that this evaluation should done by a member of staff with a minimum of level three safeguarding training. On the day of inspection, the practice updated its policy and told us that staff would be made aware.
- The practice had a range of safety policies in place which were communicated to staff and regularly reviewed. There were systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff. For example; the practice had carried out risk assessments for fire safety and legionella (legionella is a term for particular bacterium which can contaminate water systems in buildings).
- We saw the practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff who acted as chaperones had been trained for the role and most had received a DBS check. Notices were displayed in consultation and clinical rooms advising patients that chaperones were available if required. We found two members of the reception team acted as chaperones but had not been risk assessed or DBS checked. The practice evidenced that the application for a criminal check had been submitted prior to the inspection, carried out a risk assessment and assured us that these staff members would not chaperone until a satisfactory criminal check had been received.
- Staff had received up-to-date safety training and safeguarding training appropriate to their role. For example, GPs were all trained to safeguarding level three, the nursing team and healthcare assistant to safeguarding level two, and the administration staff to safeguarding level one.
- There was an effective system to manage infection prevention and control. There was a designated infection prevention and control (IPC) clinical lead in place who was supported by a deputy. An IPC audit had been carried out in July 2017 (by the Head of Health Protection for Lincolnshire NHS CCG) and an action plan (of 12 actions) had been developed to address the improvements identified. A hand hygiene audit had been carried out to assess staff compliance with the hand hygiene policy and observations and any concerns identified were documented and actioned. Clinical rooms had all been risk assessed and were audited monthly. All staff had been given access to IPC resources and policies, and the practice had introduced an isolation room and protocol for serious infection outbreak.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Due to the difficulties experienced with recruiting to GP vacancies, the partners had proactively evolved their workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of their patients and the demands on the practice. An advanced nurse practitioner (ANP) and a clinical associate, previously a paramedic, had joined the practice since the last inspection.
- There was an effective induction system for temporary staff tailored to their role. For example, we saw checklists in place for locum staff that included checks

made against their registration status, qualifications and training records. An induction pack was available and included fire procedures, external agency numbers, the appointment system, internal procedures, workflow information, staff team members and roles.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis, and were supported in making a diagnosis by automatic alerts on the clinical system.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- We reviewed referral letters and saw these included all of the necessary information. The practice used an electronic system to navigate referrals along accepted pathways. This provided comprehensive, evidenced based local guidance and clinical decision support at the point of care and is effective in reducing referrals.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. Equipment was regularly checked for both stock levels and expiry dates, all medicines we checked were found to be in date.
- The practice kept prescription stationery securely and monitored its use. The practice had a policy to inform a clinician of any uncollected prescription.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice carried out regular medicines audits, with the support of the local CCG medicines management team to ensure prescribing was in line with best practice guidelines for safe prescribing.
- One of the GP partners had started development work on a practice formulary for prescribing and the practice used a system to produce analytics on their prescribing, for example; a review had been carried out on the appropriate use of antibiotics to treat urinary tract infections.

Track record on safety

The practice had a good safety record.

- There were risk assessments in relation to safety issues in place and records of routine safety checks undertaken.
- The practice carries out annual risk assessments on each room and an environmental risk assessment to identify hazards, risks and any control measures or corrective action required.
- The practice had up to date fixed wire testing, portable appliance testing and a gas safety certificate. Wheelchairs kept at the practice to assist patients were checked annually.
- The practice did have window blinds with loop cords that had not been risk assessed.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and procedure for recording and acting on significant events and incidents. There was a standard recording form available on the practice's computer system. Staff we spoke with told us they were encouraged to raise concerns and report incidents and near misses and demonstrated an understanding of the procedure. Most staff were able to share an example of a recent significant event, the action taken and learning shared. Staff told us they were supported by managers when raising significant events.
- There were adequate systems for reviewing and investigating when things went wrong. The practice had recorded 23 significant events in the last 12 months. This represented an improvement since last inspection, highlighting that that the practice maximised opportunities for learning. Events were recorded, investigated and shared practice wide during monthly

meetings. Any learning and development was highlighted and built in to future requirements with immediate training provided where essential. For example, following the cyber-attack in May 2017, the practice had a record of events that included the background and action taken. This was then discussed at the next practice meeting.

- There was an effective system in place led by the practice manager and assistant practice manager to log and distribute to staff as appropriate. External alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety were reviewed by the duty doctor who reviewed and completed any actions required. Following an alert being reviewed and actioned, the practice discussed recent alerts in clinical or staff meetings.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice, and all of the population groups, as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice was comparable to the Clinical Commissioning Group (CCG) and national averages for antibiotic prescribing. The number of items the practice prescribed was 1.1 items compared to the national average of 1.01.
- The percentage of high risk antibiotics prescribed (Co-amoxiclav, Cephalosporins or Quinolones) was 3.87%, compared to the national average of 4.71%.
- We saw no evidence of discrimination when making care and treatment decisions.

Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or vulnerable were identified and received a full assessment of their physical, mental and social needs. Care plans were offered to all patients.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- There was a register of 560 patients over the age of 75 years, all had had a named GP, and 110 had a documented health check in their records carried out within the last 12 months.
- One of the practice nurses with a long experience as a community nurse was the assigned lead for patients over the age of 75. Home visits were provided to those patients who were housebound.
- The practice had regular communication with the district nursing team and the health and social care advisor to deliver a coordinated package of care to elderly patients.

People with long-term conditions:

- The practice offered clinics for patients with long-term conditions. Patients had a structured annual review to check their health and medicines needs were being met. Patients were provided with a management plan developed in partnership with them and agreed targets set for the next review. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training. Patients were provided with self-management plan for asthma, diabetes and chronic obstructive pulmonary disease (COPD). The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients.
- Data for 2016/17 showed 91% of patients with COPD had had a review undertaken including an assessment of breathlessness using a recognised scale in the preceding 12 months. This was above the CCG average of 88% and the national average of 90%. COPD is a chronic lung disease. The practice exception reporting rate of 19% was higher than the CCG average of 12% and above the England average of 11%.
- The percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been over a period of time was recorded as 84% compared with the CCG of 80% and the national average of 79%. The practice exception reporting rate of 9% was the same as the CCG average and lower than the national average of 12% (clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).
- The practice offered both in-house and a domiciliary phlebotomy service, warfarin dosing clinics and vitamin B12 and hormone injections at home.

Families, children and young people:

Good

Are services effective?

(for example, treatment is effective)

- Child immunisations were offered by the practice and carried out in line with the national childhood vaccination programme. Patients who missed any of their immunisations were monitored and recalled. Uptake rates for the vaccines given to under two year olds were below the target percentage of 90%. The uptake rates for vaccines given to five year olds ranged from 66% to 86%. The practice had adopted a new approach aimed at improving the uptake rates for all ages; letters to explain the immunisation programme and remind those patients who had not attended had been translated into Polish. These letters included a request for a copy of the immunisation record for those patients vaccinated when travelling to the native country of their parents. The health visitor had been informed of those patients who had not attended for immunisations.
- Antenatal clinics were held by appointment on a Tuesday with the visiting community midwife. The practice provided health surveillance clinics where the mother and baby were reviewed. There was a local children's centre where patients were could be seen by a midwife when pregnant.
- In order to increase the availability of appointments outside school and core working hours, the practice provided extended hours appointments on Mondays and Thursdays until 8pm. The practice prioritised access for unwell children.
- Baby changing facilities were provided on site and there was a poster to advice mothers that they could request a room if they wished to breastfeed their baby in private.
- Full contraception services were offered including implants and intrauterine contraceptive devices (coils).

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 82%, which was comparable with the national average of 81%. The practice exception reporting of 27% was significantly higher than the CCG average of 8% and the national average of 6%. The practice was aware of the results and explained that this resulted from the large number of foreign nationals who chose to have screening done in their country of origin.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Information about this vaccine was readily accessible and displayed in the waiting area and letters were sent to patients.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Data provided by the practice showed they had sent out 212 invitations and completed 150 of these health checks since April 2017. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- All staff had received safeguarding training (adults and children), there was a safeguarding lead and regular communication took place with social services, health visitors and the school nurse.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice hosted the palliative care meetings with a range of professionals to ensure those who were approaching end of life have a more cohesive plan of care across all agencies.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 39 registered patients with a learning disability cared for in local care homes and in their own homes. Nineteen of these patients had received an annual review. The practice had a designated nurse who was the learning disability lead and was involved in the review of these patients and was working to increase the number of reviews undertaken.
- The practice had identified 164 (1.6% of the patient list) as carers and signposted them to local services offering support and guidance.
- One of the GP partners was qualified to provide looked after children assessments. This service was offered to both registered and non-registered patients.
- Patients identified as at risk of overdosing were monitored regularly; prescriptions were limited to being issued weekly.

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

Good

Are services effective?

(for example, treatment is effective)

- The practice had a designated GP mental health lead.
- Same day appointments and same day telephone assessment was provided tor those patients with acute mental health problems.
- 85% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months compared with the CCG average of 87% and the national average of 84%. The practice exception reporting rate of 11% was the same as the CCG average and higher than the national average of 7%.
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the CCG average of 86% and the national average of 90%. The exception reporting rate of 28% was higher than the CCG average of 22% and national average of 13% meaning fewer patients had been included.
- The practice provided signposting to local support services and online resources for those patients experiencing poor mental health.

Monitoring care and treatment

The practice had a structured programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice had carried out audits to include a full cycle audit on women over the age of 35 at potential risk from a popular form of combined oral contraceptive. The audit had been repeated annually for the last four years and included a review of risk factors that included smoking, age and body mass index (BMI). Results showed improvements were achieved each year, with the number of patients classified as at risk having reduced from 67 in 2013 to 22 in 2017.

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 for 2016/17 showed the practice had achieved 99% of the total number of points available compared with the clinical commissioning group (CCG) and the national averages of 95%. The practice clinical exception rate of 13% was higher than the CCG and the national average of 10%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training opportunities for personal development. Newly appointed staff received an induction to their work. Records of staff skills, qualifications and training were maintained. A training had been identified and records checked evidenced that staff received up-to-date essential training to enable them to carry out their duties safely. For example, safeguarding, infection control and fire safety awareness.
- Staff were encouraged and given opportunities to develop. This included staff recruited from outside primary care and developed at the practice. For example; an advanced nurse practitioner (ANP) was supported to transfer from secondary care (hospital), and a paramedic had been developed to become a clinical associate.
- The practice provided staff with ongoing support. This included an induction process, appraisals, tutorials, clinical supervision, lunchtime briefing sessions and support for revalidation. Two clinicians we spoke with considered the practice could provide more structured opportunities to discuss their learning.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when

they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Meetings were held with external healthcare partners to discuss patients with complex needs. The palliative care meetings included an audit on deceased patients' place of death.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, patients could attend clinics where they were supported to stop smoking and a free weekly Zumba class was regularly attended by 30-40 patients.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health and supported and signposted patients that required support.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- Clinicians were able to share examples of how and what procedures they obtained consent for. For example, written consent was obtained for immunisations, minor surgery, contraceptive intrauterine devices (coil) and implants.

Requires improvement

Are services caring?

Our findings

We rated the practice, and all of the population groups, as requires improvement for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.
- The 31 patient Care Quality Commission comment cards we received were generally positive about the service experienced. Patients complimented the practice on providing an excellent service and two patients specifically commented positively on the provision of translators. Four of the comments were mixed; although they complimented the practice on a good service, two mentioned difficulties in securing a GP appointment, one highlighted that the self-check in screen had been out of order for some time and one found the approach from some locum GPs rushed.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Three hundred and eighteen surveys were sent out and 115 were returned (a return rate of 36%; equivalent to 1.1% of the practice population).

Patient satisfaction scores for consultations with GPs were below the CCG and national averages. For example:

- 78% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 77% of patients who responded said the GP gave them enough time; compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; compared with the clinical commissioning group (CCG) average of 94% and the national average of 95%.
- 78% of patients who responded said the last GP they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) average of 84% and the national average of 86%.

The practice told us that they had received multiple complaints from patients about the attitude of an individual GP. Peer support had been provided to the GP to improve how consultations were handled.

However , the patient satisfaction scores for consultations with nurses were similar to local CCG and national averages;

- 93% of patients who responded said the nurse was good at listening to them; compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 91% of patients who responded said the nurse gave them enough time; compared with the clinical commissioning group (CCG) and the national averages of 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; compared with the clinical commissioning group (CCG) and the national averages of 97%.
- 88% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) and the national averages of 91%.

The national patient survey scored the practice below local CCG and national averages for patient feedback on the reception staff;

- 75% of patients who responded said they found the receptionists at the practice helpful; compared with the clinical commissioning group (CCG) average of 84% and the national average of 87%.

The practice had reviewed the results and the survey as a result, sent reception staff on 'customer service training' and 'care navigation training'.

Involvement in decisions about care and treatment

Requires improvement

Are services caring?

Staff helped patients be involved in decisions about their care. Interpreters were employed by the practice and provided a full range of translation services into Polish as well as conversational Russian. Interpretation services were available for patients who did not have English or Polish as a first language. Notices were displayed in the reception areas advising patients of this service, the staff we spoke with were able to tell us how they would support a patient with accessing this external service in addition to obtaining information in a variety of formats, for example, large print.

- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs and staff if a patient was also a carer and referred them to a local voluntary carers association The practice had identified 164 patients as carers (1.6% of the practice list). There was information provided on the practice website to support carers that included links to carers support groups and the contact details for Carers Direct.

- Staff told us that if families had experienced bereavement, they passed on their condolences, were offered an appointment with a GP and signposted to local counselling services. Information was available on the practice website to support families in times of bereavement.

Results from the national GP patient survey showed patients responses to questions about their involvement in planning and making decisions about their care and treatment. Results were below local and national averages:

- 79% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 84% and the national average of 86%.
- 67% of patients who responded said the last GP they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) average of 79% and the national average of 82%.
- 84% of patients who responded said the last nurse they saw was good at explaining tests and treatments; compared with the clinical commissioning group (CCG) and the national averages of 90%.
- 80% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) average of 86% and the national average of 85%.

The practice told us that they attributed the scores to the high use of locum GPs to improve access while trying to recruit additional salaried GPs and Advanced Nurse Practitioners (ANPs).

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Staff told us that a private area would be made available should a patient wish to discuss sensitive issues or their prescriptions.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours, online services such as repeat prescription requests and the recruitment of multilingual staff.
- The practice had reviewed and increased its workforce and employed additional clinicians with a varied skill mix to help meet the health and social needs of patients and the demand for access to appointments.
- The practice improved services where possible in response to unmet needs. For example, the practice had recruited a clinical pharmacist having recognised that time pressure on GPs had resulted in a reduction in the number of medication reviews completed.
- The facilities and premises were appropriate for the services delivered. Consultation and treatment rooms were all on the ground floor, entrance doors were automated and height adjustable couches were available.
- The practice hosted ultrasound and physiotherapy services to reduce the need for patients to travel to receive these services in hospital.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations were available with a duty GP for patients unable to access the practice within normal opening times. Home visits were provided for patients who were housebound or had enhanced needs.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- GPs, the advanced nurse practitioner (ANP) and the clinicians associate carried out home visits when required and offered support and advice over the telephone.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- The practice provided a number of long term condition clinics in order to support patients to manage these conditions, monitor their wellbeing and develop management plans in conjunction with them.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice held regular meetings with external health professionals to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice had 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 accident and emergency (A&E) attendances.
- Appointments were offered outside school hours for school aged patients and children were seen on the same day.
- Antenatal clinics were held by appointment each week with the visiting community midwife. The practice provided health surveillance clinics where the mother and baby were reviewed.
- Full contraception services were offered including implants and intrauterine contraceptive devices (coils).

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours appointments were offered on Monday and Thursday evenings in order to offer the greatest flexibility for patients.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- NHS Health Checks were provided for patients aged 40 to 74 and patients were given lifestyle advice on exercise and diet.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice was proactive in supporting the local authority with any patients with safeguarding issues and had met with social workers and attended multi-disciplinary team meetings to support other clinicians in the care of these patients.
- The practice hosted the palliative care meetings with a range of professionals to ensure those who were approaching end of life have a more cohesive plan of care across all agencies.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice provided same day appointments and telephone consultations for patients with acute mental health problems.
- The practice proactively managed their registers of patients with a recall system for mental health annual reviews that included dementia screening as part of the consultation.
- The practice signposted patients to local mental health services and to online resources to support those experiencing poor mental health.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had access to initial assessment, test results, diagnosis and treatment.
- Some patients found it difficult to make a routine appointment to see a GP.
- Patients with the most urgent needs had their care and treatment prioritised.

Results from the national GP patient survey published in July 2017 showed that patients' satisfaction with how they could access care and treatment was generally below local CCG and national averages, For example:

- 79% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 49% of patients who responded said they could get through easily to the practice by phone; compared with the clinical commissioning group (CCG) average of 58% and the national average of 71%.
- 63% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; compared with the clinical commissioning group (CCG) average of 80% and the national average of 84%.
- 60% of patients who responded said their last appointment was convenient; compared with the clinical commissioning group (CCG) average of 78% and the national average of 81%.
- 57% of patients who responded described their experience of making an appointment as good; compared with the clinical commissioning group (CCG) average of 66% and the national average of 73%.
- 37% of patients who responded said they don't normally have to wait too long to be seen; compared with the clinical commissioning group (CCG) and the national average of 58%.

This was supported by discussions held with patients on the day of inspection and comment cards. The practice acknowledged that access by telephone continued to be problematic for patients and as a result had provided 'care navigation training' and 'customer service training' to help receptionists improve call handling efficiency. The practice told us there had been a problem with the queue option on the telephone system and patients were experiencing long waits. After receiving complaints, the practice had the problem fixed and told us that no complaints had been made since. In addition, extra reception staff had been allocated to call answering in the first hour of the day and repeat prescription requests were diverted to a separate line to free up the access for making appointments.

The practice was proactively working to improve access to appointments. An advanced nurse practitioners and a clinical associate had been appointed to reduce the demand on GP appointments. In response to long wait times, the practice highlighted that with ethnic diversity, the use of translators often extended consultation times. The practice told us they planned to streamline the use of translators into specific times of the day to help this. There

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

was a notice in the patient waiting areas asking people if they needed more time with GP, then to make the receptionist aware so that a double appointment would be booked for them.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to continually improve the quality of care.

- Information about how to make a complaint or raise concerns was accessible in the practice and information on the practice website, although not updated with the responsible member of staff, signposted and instructed patients on how to make a complaint. We saw that the complaint leaflet and letters of response to complainants included details of how to complain to the NHS Ombudsman should a patient not be satisfied with the outcome of their complaint. Information on how to make a complaint was available on the practice website.
- A GP partner was the designated lead for managing complaints. The complaint policy and procedures were in line with recognised guidance. We saw 32 complaints had been recorded in the last 12 months. We reviewed a sample of recent complaints and found that they were satisfactorily handled in a timely way. The practice told us that informal analysis of trends identified that the attitude of an individual GP was a common theme in patient complaints. The practice told us that peer support was provided to the GP to improve how consultations were handled. The minutes of meetings evidenced that complaints were discussed, but there was no specific evidence to record discussions held.

Are services well-led?

Good

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, due to the difficulties recruiting to GP vacancies the practice had reviewed and increased its workforce and skill mix. The practice had employed an advanced nurse practitioner (ANP) and a paramedic to reduce the demand on GP appointments and to provide an alternative complimentary source of primary healthcare alongside services traditionally provided by its GPs.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff had lead roles and were aware of their roles and responsibilities.
- The practice had effective processes to develop leadership capacity and skills, including planning for the introduction of a clinical pharmacist.
- The practice were proactive in their approach to tackling GP recruitment and retention problems and had started a project with the Local Medical Committee (LMC) to recruit foreign doctors and enable them to work in England.
- The practice made best use of their clinical skills with appointed leads in areas of specific specialisms for GPs.

Vision and strategy

The practice had a credible strategy to deliver high quality care and promote good outcomes for patients. There was a written five year business plan that included a planned merger with the GP surgery situated in the same building.

- The practice had written a mission statement and a set off aims, this was 'to provide the highest quality primary health care to patients and their family in the area'.

  Some staff and patients we spoke with felt that the future plans for the practice could be better communicated although a public consultation on the planned merger had been held.
- The practice planned its services to meet the needs of the practice population. For example, the practice employed Polish speaking translators and had increased its capacity for urgent care by recruiting an ANP; increasing efficiency by making sure the right staff members were doing the right work.
- The practice had a five year business plan that was reviewed and updated annually. The plan was subdivided into plans for the building, the staff development and patient care.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice and told us that social events held throughout the year helped create effective team working and good staff morale.
- The practice focused on the needs of patients and staff.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed and had access to a policy in the event of needing to raise concerns in relation to staff practice in the workplace.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff had received an annual appraisal in the last year and were supported to meet the requirements of professional revalidation where necessary. The advanced nurse practitioner (ANP) and clinical associate complimented the GP partners on the support and development provided to them, for example; standard consultations were 20 minutes and daily reviews sessions took place with a GP after clinics.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for attending various meetings held in addition to professional development and evaluation of their clinical work.

Are services well-led?

Good

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

- The practice actively promoted equality and diversity. However, staff had not yet received training in this area. Staff felt they were treated equally and reported there were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- There was a schedule of governance meetings that included a monthly clinical meeting, a fortnightly partner meeting, a monthly practice meeting (for administration staff) and monthly safeguarding and palliative care meetings. In addition the practice normally held full practice meetings at least once a year. All meetings were minuted, and minuted were made available to update those members of staff unable to attend.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- The practice had established policies and procedures however; we saw these were not always reviewed by the GP partners.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. For example; an environmental health and safety risk assessment had been completed to identify hazards and mitigate potential risks.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through checks and discussions of their consultations, prescribing and referral decisions. Practice leaders had oversight of incidents, and complaints in addition to external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety.
- Clinical audit had a positive impact on quality of care and outcomes for patients.
- The practice had plans in place for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG) that met quarterly. Meetings were chaired by a patient chairperson and they told us that the deputy practice manager supported with administrative duties. During the inspection we met with two members of the group. They told us the practice were actively involved with meetings; and one of the GP partners normally attended. Plans were shared with them and they felt their suggestions were listened to and acted upon. For example, a request to improve telephone access resulted in training for reception staff aimed at

Are services well-led?

Good

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

improving efficiency. We saw PPG meetings were recorded and there was information available to actively encourage new members to the group that reflected the diversity of the practice population.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The focus on continuous learning and improvement at all levels within the practice was clearly evidenced through the significant improvements made since the last inspection.
- The practice aimed to improve the range of services available to the local community from the premises. The areas that had been targeted were dermatology and cardiology where the practice planned to bid to be an approved provider following the planned closure of services currently provided at the local hospital.
- The practice had recently commissioned an external report to review and compare their prevalence levels with other local practices.
- The practice was working with another practice based in the same building towards a merger planned for April 2018. The GPs and practice managers met regularly to share best practice, take the work forward and to strengthen and support each other and ensure future sustainability.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice was a training practice and currently had a GP registrar and a trainee doctor (foundation year two). The practice was registered with a local university and worked with them on providing work experience placements to trainee health professionals, for example; undergraduate medical students and nursing students.