Hilton Road Surgery

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
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 Hilton Road Surgery on 21 July 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing well-led, caring and responsive services. However it was rated as requires improvement for safe and effective services. It was rated as good for providing services for all population groups other than for the care of people whose circumstances may make them vulnerable where they are rated as requires improvement.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Most information about safety was recorded, monitored, appropriately reviewed and addressed.
- The majority of patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services was available and easy to understand.
- Patients said they found the appointment system very accessible.
- The practice had adequate facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

There were areas of outstanding practice.

Summary of findings

- We found there was outstanding practice to support women, where English was not their first language, to access cervical screening and improve cervical screening uptake. Cervical screening rates at the practice were 85% slightly above the national average of 81.88%. The practice had also developed a health champion role and weekly drop-in clinics had been implemented for women to discuss health topics such as cervical screening. (Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offered and to help to meet the health needs of patients and the wider community).

However there were areas of practice where the provider should make improvements.

- It was not clear if information from external sources such as National Patient Safety Agency (NPSA) was disseminated to relevant staff and that appropriate action had been taken.
- Patients at risk were not routinely highlighted on the electronic patient record system.
- Records did not show if clinical staff had undertaken recommended level three training in safeguarding children.
- Staff registration with the appropriate professional body was checked upon employment but was not checked on an annual basis to ensure that registration had not lapsed.
- There was a lack of evidence that the prevalence of some diseases had been assessed in order to show they were identifying all patients with long term conditions.
- The practice had not carried out annual health checks for people with a learning disability.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

There were some areas for improvement.

It was not clear if information from external sources such as National Patient Safety Agency (NPSA) was disseminated to relevant staff and that appropriate action had been taken.

Patients considered to be at risk were not routinely highlighted on the electronic patient record system.

Records did not show if clinical staff had undertaken recommended level three training in safeguarding children.

Staff registration with the appropriate professional body was checked upon employment but was not checked on an annual basis to ensure that registration had not lapsed.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) 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.

We found there was outstanding practice to support women where English was not their first language to access cervical screening and improve cervical screening uptake. The cervical screening uptake was 85% at the practice which was slightly above the national average of 81.88%.

There were some areas for improvement

Summary of findings

There was a lack of evidence that the prevalence of some diseases had been assessed in order to show they were identifying all patients with long term conditions.

Are services caring?

Good

The practice is rated as good for providing caring services. 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 appointments available the same day. The practice had adequate facilities and was 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 and strategy. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. It was responsive to the needs of older people and offered home visits and longer appointments where required.

People with long term conditions

Good

The practice is rated as requires improvement for the care of people with long-term conditions. There was a lack of evidence that the prevalence of some diseases had been assessed in order to show they were identifying all patient's with long term conditions. Reviews to check health and medication needs were available but patient's had to attend for multiple appointments if they had multiple conditions. The practice was working to improve this and processes were in place to implement changes.

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. 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 is rated as good for the care of families, children and young people. Children at risk were not routinely highlighted on the electronic patient record system.

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. Appointments were available outside of school hours.

We found there was outstanding practice to support women where English was not their first language to access cervical screening and improve cervical screening uptake and cervical screening rates were higher than the national average. The practice had also developed a health champion role and weekly drop-in clinics had been implemented for women to discuss health topics such as cervical screening. (Practice Health Champions are people who voluntarily

Summary of findings

give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offered and to help to meet the health needs of patients and the wider community).

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice did not hold a register of patients living in vulnerable circumstances including children and those with a learning disability. It had not carried out annual health checks for people with a learning disability.

The practice 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. Longer appointments were offered for people where required.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. The practice had a range of enhanced services including dementia and used a dementia tool as part of the dementia identification scheme. Longer appointments were available for this group of patient's.

Summary of findings

What people who use the service say

We received 62 CQC patient comment cards and spoke with three patients on the day of our visit. We spoke with people from different age groups and with people who had different physical needs and those who had varying levels of contact with the practice.

Patients told us they were very satisfied with the service they received. They described the service as excellent, brilliant, very good and efficient. A number of comments described the doctors, nurses and reception staff as caring, helpful and respectful.

The patients were complimentary about the care provided by the clinical staff. They told us the staff listened to them, explained treatments to them and involved them in decisions about their care. Patients described how well supported they were with their long term health conditions and they said they had been offered regular health checks. A number of people described their care as effective and were complimentary about the referral process for secondary care. We received a couple of negative comments about a lack of consistency in seeing the same GP.

Patients told us all the staff treated them with dignity and respect. Patients were complimentary about the support they received from the administration and reception staff.

Four patients commented they had found it difficult to get an appointment and said waiting times were too long. However the majority were positive about the appointment system which had been changed in June 2015 to incorporate drop in clinics. Patients told us they liked the new appointment system with the drop in clinics. They said the system offered them flexibility and they knew they could always be seen on the same day which they found reassuring. A patient survey completed by the practice in June 2015 to check the new arrangements told us that 87% of patients found the drop in clinics useful

Patients told us that confidentiality in the waiting area could be an issue due to the small size of this area. However patients we spoke with knew that a private room was available if required.

Patients said the practice was always clean and tidy.

We received information from the National Patient Survey. The information from the latest GP Patient Survey report published in January 2015 showed there were 431 survey forms distributed for Hilton Road Surgery and 70 forms were returned. This is a response rate of 16.2%. The results showed that 75% of patients described their overall experience of this surgery as good. The average for the local Clinical Commissioning Group (CCG) area was 87% and the national average was 85%.

The practice showed us evidence of the response they had in the Friends and Family test. The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The results showed the practice had recieved 403 responses between January and June 2015 and 81% of respondents said tehy would recommend teh practice to their family and friends.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

It was not clear if information from external sources such as National Patient Safety Agency (NPSA) was disseminated to relevant staff and that appropriate action had been taken.

Patients considered to be at risk were not routinely highlighted on the electronic patient record system.

Records did not show if clinical staff had undertaken recommended level three training in safeguarding children.

Staff registration with the appropriate professional body was checked on employment but was not checked on an annual basis to ensure that registration had not lapsed.

Summary of findings

There was a lack of evidence that the prevalence of some diseases had been assessed in order to show they were identifying all patients with long term conditions.

The practice had not carried out annual health checks for people with a learning disability.

Outstanding practice

We found there was outstanding practice to support women to access cervical screening.

Some patients who may be in need of extra support were identified by the practice; this included those where English was not their first language. One of the reception staff told us how they had worked with women in this group in order to improve cervical screening uptake. They had contacted the women, explained the procedure and acted as a chaperone for them when requested to alleviate anxiety. The cervical screening uptake was 85% at the practice which was slightly above the national average of 81.88%. We also spoke with the Practice Health Champion who told us they had organised weekly women only sessions to discuss health topics and as part of this they had included a cervical screening awareness session. (Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services that the practice offered and to help to meet the health needs of patients and the wider community).

Hilton Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Inspector. The team included a GP and a practice manager specialist advisor.

Background to Hilton Road Surgery

Hilton Road Surgery is situated within a converted end terraced house in Leeds.

The practice provides Alternative Provider Medical Services (APMS) for 2000 patients under a contract with NHS Leeds North Clinical Commissioning Group (CCG).

There are five salaried GPs, four male and one female. The clinical team also includes an advanced nurse practitioner, a practice nurse and a health care assistant. An experienced team of management, administrative and reception staff support the practice. This practice is part of One Medicare Ltd who operates a number of practices across the country.

The practice opening times are Monday to Friday 8am to 6pm with extended hours on a Thursday until 7pm. Drop in clinics are available Monday, Tuesday, Thursday and Friday from 9.20am to 11.40am.

Local Care Direct provides services between 6 pm and 6.30 pm. Calls to the practice are automatically redirected to this service. Between 6.30 pm and 8 am out of hours services are also provided by Local Care Direct and are accessible by calling the NHS 111 service.

The practice is registered to provide the following regulated activities; family planning, diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

Why we carried out this inspection

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

Please note 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 the 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?

Detailed findings

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
- 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 visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the NHS Leeds North CCG, to share what they knew.

We carried out an announced visit on 21 July 2015. During our visit we spoke with a range of staff including two GPs, advanced nurse practitioner, practice nurse, health care assistant, office manager and three administration staff. We spoke with three patients who used the practice.

We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We reviewed 62 CQC patient comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice demonstrated that it was safe over time through the safe management of incidents, concerns and near misses. All staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally where appropriate.

The staff we spoke with could not provide evidence to indicate how information from external sources such as the National Patient Safety Agency (NPSA) was shared. The lead GP told us they shared the NPSA alerts with staff via email but there were no records to evidence this or evidence of any actions taken in response to the alerts.

Learning and improvement from safety incidents

Lessons were learned and improvements were made when things went wrong. When things went wrong investigations and significant event or incident analyses was carried out. Relevant staff and patients who used the practice were involved in the investigation.

There was some evidence, through significant event audits and meeting minutes, to show the actions taken and lessons learned. However the records of actions taken were not always clearly recorded in the minutes of meetings. Staff told us outcomes of investigations and lessons learned were always shared with them to make sure action was taken to improve safety in the practice. For example, reception staff told us where there had been an incident with a patient who had a similar name to another patient, processes had been put in place to minimise the risk of a similar occurrence.

Reliable safety systems and processes including safeguarding

There were systems, processes and practices in place to keep people safe and safeguarded from abuse. Training records and discussions with staff showed us staff were trained and made aware of these systems and processes.

The training records we saw did not indicate the level of safeguarding training clinicians had received. The lead GP told us they had completed level 3 training although we did not see evidence of this in records.

We saw some evidence systems were in place to highlight vulnerable patients on the practice's electronic records to make staff aware of any relevant issues when patients attended appointments. However, the electronic system had not been used to its full extent in order to ensure all patients at risk were highlighted. For example, there was no register of children subject to child protection plans and alerts had not been used to highlight these patients on the system. This was addressed on the day of the inspection by the lead GP. There was also a lack of understanding by some staff of the alerts that could be used on the system to highlight vulnerable patients. We found the reception staff and GPs had a good local knowledge of families and any mitigating risk factors.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Administration staff would act as a chaperone if required. Appropriate recruitment checks had been completed and they had received training, staff we spoke with understood their responsibilities when acting as chaperones.

Medicines management

The arrangements for managing medicines in the practice were in line with best practice (This included obtaining, prescribing, recording, handling, storing and security, dispensing, safe administration and disposal).

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear procedure for ensuring medicines were kept at the required temperatures. The practice staff maintained records to show refrigerator temperatures were checked regularly.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness and infection control

Requires improvement

Are services safe?

Standards of cleanliness and hygiene were safely maintained. There were reliable systems in place to prevent and protect patients from a healthcare-associated infection. The arrangements for managing waste and clinical specimens minimised the risk of cross infection. (This included classification, segregation, storage and labelling and handling of waste). A detailed infection prevention and control audit had been undertaken in June 2015. Minor points for action had been identified and the majority of these had been addressed.

We observed all areas of the practice were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection prevention and control (IPC).

Equipment

The design, maintenance and use of the facilities premises and equipment kept patients safe. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing and calibration of equipment was in place and up to date.

Staffing and recruitment

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

Actual staffing levels and skill mix matched the planned staffing levels the majority of the time. Cover was provided for staff on annual leave either by the practice staff or through the use of staff from another local practice within the organisation.

Staff identified and responded to changing risks to patients who used the practice by monitoring them for deteriorating health and wellbeing and through the safe management of medical emergencies. We heard from reception staff how they had received training to deal with an emergency and they said they were able to seek support from clinical staff in these situations.

Records we looked at contained evidence appropriate recruitment checks had been undertaken. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

We saw that while registration with the appropriate professional body was checked upon employment this was not routinely checked on an annual basis to ensure that registration had not lapsed.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see. The majority of staff were up to date with health and safety, fire awareness and moving and handling training or training was scheduled.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. The risk log was reviewed monthly by the practice manager. We saw that any risks were discussed at GP partners' meetings and within team meetings. .

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A detailed business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included action to take if there was a power failure, adverse weather, unplanned sickness or loss of the telephone system. The document also contained relevant contact details for staff to refer to.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs told us they discussed relevant and current evidence-based guidance, standards, best practice and legislation such as information from the National Institute for Health and Care Excellence (NICE), in the clinical meetings. There was some evidence from discussions with clinical staff they identified and used this information to develop how care and treatment was delivered to meet needs. This included during assessment, diagnosis, referral to other services and the management of long-term conditions, including for patients in the last 12 months of their life. However, there was a lack of evidence to show the practice had considered and assessed the prevalence of some diseases within the practice population in order to ensure they were identifying all patients with long term conditions. For example, we saw that while the prevalence of diabetes was higher at this practice, the prevalence of atrial fibrillation, coronary heart disease and chronic obstructive pulmonary disease (COPD) was much lower than expected for the area. The lead GP told us they were aware of this. They told us they had, together with the local Clinical Commissioning Group (CCG), conducted an audit of patients prescribed an inhaler to ensure the patients with COPD had been correctly coded on their patient records. However when we spoke to a member of the clinical team who assisted with patient reviews we found they had not been routinely undertaking appropriate assessments using spirometry although equipment for this was available (spirometry is a test that can help diagnose various lung diseases, most commonly COPD). They told us they would use this in future.

The office manager told us they had employed a staff member to summarise and code patient records and that this would assist the practice to identify patients with a long term conditions. This member of staff had been in post for 18 months

We saw new patients were offered health checks and NHS health checks for patients over 40 years of age were also offered. We also saw the needs of patients discharged from hospital were reviewed by a GP.

Management, monitoring and improving outcomes for people

Patients' care and treatment outcomes were monitored. We saw that that there were systems in place to recall patients with long-term conditions for regular health checks. However, patients with multiple conditions had multiple appointments rather that one appointment for all the checks to be completed at the same time. The office manager told us they were working towards an annual appointment review system to improve this area for patients. Staff training was scheduled to enable these changes to take place.

Information showed that the intended outcomes for patients were being achieved. Outcomes for patients in this service were as expected when compared to other services although the issues relating to identifying patients with long term conditions may have had some impact on the data we reviewed. Staff were involved in activities to monitor and improve patient outcomes. Performance for diabetes, mental health and hypertension related indicators was similar to the national average. The dementia diagnosis rate was also comparable to the national average.

Clinical audits were carried out and relevant staff were involved. We looked at two audits relating to prescribing medicines against recommended guidelines. For example, we saw that one audit had looked at prescribing practice in relation to antibiotics, taking into consideration the length of a course, strength of the medicine and choice of medicines prescribed. We saw that learning to improve practice and outcomes for patient's had been shared.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. We were provided with evidence that staff had the right qualifications, skills, knowledge and experience to do their job on appointment. 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, appraisals and clinical supervision. GPs we spoke with told us they were up to date with their continuing professional development requirements. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every

five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Where poor or variable staff performance was identified the practice had policies and processes to ensure this was effectively managed.

Working with colleagues and other services

Staff and services worked together proactively to deliver effective care and treatment. Care was delivered in a coordinated way when different services were involved. For example, we were shown the process for coordination between daytime GP practices and GP out-of-hours care and with NHS 111 services.

Staff worked together and with other health and social care services to assess and plan ongoing care and treatment in a timely way when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence multi-disciplinary team meetings took place on a bi-monthly basis and care plans were routinely reviewed and updated.

There were clear and effective arrangements for referrals and follow-up for patients who had been referred to other services using the NHS online referral service. For example, staff told us that they used the choose and book system and offered patients a choice. Staff told us they assisted patients by ensuring transport and interpretation services were also requested at the time of referral, where required.

Emergency hospital admission rates for the practice were similar to the national average. The practice had a process in place to follow up patients discharged from hospital. Staff described how a GP had dedicated time to review discharge letters against patient notes. They told us patients were contacted to check their health and they were called for a health review if necessary.

Information sharing

Staff had all the information they needed to deliver effective care and treatment to patients who used services. All the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practices patient record system (SystmOne) and their intranet system. This included care and risk assessments, care plans, case notes and test results. Information, such as NHS patient information leaflets, was also available.

When patients moved between teams and services, including at referral and transition, all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols. The practice showed us a palliative care handover form which was completed and shared with the local out of hour's services in respect of patients receiving palliative care. This included details about their medical background, care planning and the patient's wishes.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Some clinical staff we spoke with had received training and understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. We found a health care assistant had not received training and had little knowledge in this area although they had been employed for more than 12 months. We were told they were supported by the nursing team and training was to take place when a course was available.

GPs told us they had received training to assist them to support patients where their mental capacity to consent to care or treatment was unclear. They were able to describe how they would assess the patient's capacity and, where appropriate, record the outcome of the assessment.

Health promotion and prevention

Patients were supported to live healthier lives. There were screening and vaccination programmes for all groups of patients and those who did not attend were followed up. Flu vaccination rates for the over 65s were 52.49 %, and at risk groups 74.88%. These were similar to national averages. Child immunisation rates were at 94%.

- Some patients who may be in need of extra support were identified by the practice; this included those where English was not their first language. One of the reception staff told us how they had worked with women in this group in order to improve cervical screening uptake. They had contacted the women, explained the procedure and acted as a chaperone for

Requires improvement

Are services effective?

(for example, treatment is effective)

them when requested to alleviate anxiety. The cervical screening uptake was 85% at the practice which was slightly above the national average of 81.88%. We also spoke with the Practice Health Champion who told us they had organised weekly women only sessions to discuss health topics and as part of this they had included a smear test awareness session. Practice Health Champions are people who voluntarily give their time to work with the staff in their local GP Practice or surgery to find new ways to improve the services the practice offers, and to help to meet the health needs of patients and the wider community. We were told us the practice was very engaged and supportive of this initiative.

The practice could not evidence they had comprehensively identified all patients who were at risk of developing a long-term condition such as heart failure and COPD. However, they had introduced initiatives to improve the identification of patients at risk of diabetes and had worked jointly with the local CCG and other practices to improve diabetes care. This had a positive impact on identifying patients at risk of developing diabetes and data showed they were above the national average in this area. Together with other practices they had used funding to jointly employ a diabetic nurse who was to commence employment in September 2015.

Patients had access to health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-up on the outcomes of health assessments and checks were made where risk factors were identified. However the practice had not carried out annual health checks for people with a learning disability.

They were able to refer patients with high blood pressure and obesity to a health trainer who attended the practice weekly.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The staff at the practice treated people with kindness, dignity, respect and compassion while they received care and treatment. Data sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was rated 'among the best' for patients who had confidence and trust in the last GP they saw or spoke to at 97%. This was slightly above the Local (CCG) average of 96% and national average of 95%% in this area.

The majority of the 62 completed patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Seven comments were less positive but there were no common themes to these. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We observed staff were careful when discussing patients' treatments so that confidential information was kept private. Some patients commented that the waiting area was small so confidentiality may be difficult to maintain. However, patients we spoke with knew that a private room was available if required. We saw the room was close to the reception area and a notice informing patients of this facility was displayed in reception. We received very complimentary comments about the reception staff. Patients told us the receptionists were very polite, considerate and helpful.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients had rated their involvement in planning and making decisions about their care and treatment below the local (CCG) and national average. For example, 70% said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the local (CCG) average of 84% and national average of 81%.

However, the patients we spoke with on the day of our inspection told us that health issues and treatment options were discussed with them. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also very positive and aligned with the views of patients we spoke with.

Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients rated the practice below the local (CCG) and national average for the emotional support provided by the practice. For example, 86% said the last GP they saw or spoke to was good at listening to them compared to the local (CCG) average of 91% and national average of 89%. Patients had also rated the practice below local CCG and national averages for being good at treating them with care and concern. For example, 74% of patients rated nurses as good in this area compared to the local average of 91% and national average of 90%. However, the patients we spoke with on the day of our inspection and the comment cards we received were not consistent with this survey information. For example, comments we received highlighted that patients felt listened to and they told us staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. Some leaflets were available in several languages on request although this was not advertised in the waiting area.

The practice had not utilised their computer system to show an alert if a patient was also a carer. However the reception staff had a good local knowledge of the patient's and their circumstances and were able to give examples of the support offered to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of different people were taken into account when planning and delivering services. For example, longer appointments were available for older patients, those with complex needs and for those who required the services of a translator. The practice had employed a female GP in response to patient concerns about the staff mix in the last survey.

Care and treatment was coordinated with other stakeholders, commissioners and providers. For example, the practice was working with other local practices to improve the care for patients with diabetes and they had used funding to jointly employ a diabetic specialist nurse.

Where people's needs were not being met, this was identified and used to inform how services were planned and developed. For example, patients had to attend multiple appointments for health reviews where they had multiple long term conditions. The practice was changing this system to an annual check for all conditions and staff training was scheduled to enable these changes to be implemented.

Tackling inequity and promoting equality

Services took account of the needs of different people, including those in vulnerable circumstances. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. For example, the practice had provided an extended hours service one evening per week which would meet the needs of working age patients and students.

Reasonable adjustments were made and action was taken to remove barriers where peoplefound it hard to use or access services. For example, the facilities and premises created some challenges for the practice. The practice was situated in an end of terrace house over three floors. The patient areas were situated on the first and second floor. The stairs were steep and no lift was available. The staff and patients told us that where patients could not access the stairs the ground floor surgery was used for their consultation. There were also steps with a low handrail to the main front entrance. The staff and patients told us level access was available via the side or rear of the premises. Staff and patients told us these measures worked well and no concerns were raised on the day of the inspection or on the 62 comment cards we received. Home visits were available for patients where required. The practice had listened when a patient had complained about safety for children posed by the steep staircase and had put measures in place to reduce risk.

Access to the service

The patient survey information we reviewed showed patients rated the practice below the local (CCG) and national average for access to the service. For example, 67% of patients described their experience of making an appointment as good compared to the local (CCG) average of 77% and national average of 73%.

The data also showed that although the patients could get through to the practice easily by phone they had to wait too long to get an appointment. For example, 87% said they could get through easily to the surgery by phone compared to the CCG average of 79% and national average of 73%. However only 46% felt they didn't normally have to wait too long to be seen compared to the local (CCG) average of 61% and the national average of 58%.

The practice had identified the appointment system as an area for improvement and had implemented four morning drop in clinics per week and extended hours one evening per week.

We found the majority of CQC comment cards and the patients we spoke with were positive about the appointment system. Patients told us they really liked the new appointment system with the drop in clinics. They said the system offered them flexibility and they knew they could always be seen on the same day which they found reassuring. A patient survey completed by the practice in June 2015 to check the new arrangements told us 87% of patients found the drop in clinics useful.

Access to appointments and services was managed to take account of patient's needs, including those with urgent needs. Patients told us a GP would call them to discuss their health problem if they were unable to get an appointment for the same day but they said they could usually get a same day appointment if necessary.

Patients told us they were kept informed of any delays. They said appointments usually run on time and waiting times were not too long at the drop in clinics.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information about appointments was available to patients on the practice website. There was also information about arrangements to ensure patients received urgent medical assistance when the practice was closed.

Listening and learning from concerns and complaints

Systems for complaining or raising concerns were easy for patients to access. For example, some basic information about the complaints procedure was available on the website and leaflets were available in the practice.

People's concerns and complaints were listened and responded to and used to improve the quality of care. We saw where patients had raised complaints with the practice or on the NHS choices web site these had been addressed. We saw action had been taken in response to complaints to improve practice and that learning had been shared with staff. For example, where a patient had complained about the safety of stairs for young children action had been taken to minimise the risk. The patient had then commented positively on the changes.

Patients told us they had not had to make a complaint but would feel comfortable to do so.

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. It was evident through our discussions with staff and patients that the provider had worked hard towards delivering their vision and had overcome some challenges to achieve this including high staff turnover and a reliance on locum GPs. The staff and patient's told us that the practice now had a stable staff team which had enabled them to make improvements to the service and this had increased patient satisfaction.

The practice continued to look at how they could improve the service and worked closely with the local CCG and other local practices to develop their services.

Governance arrangements

Governance systems in the practice were underpinned by a clear staffing structure, a staff awareness of roles and responsibilities and practice specific policies which were accessible to all staff on the desktop computers.

We also saw there was a system of reporting incidents without fear of recrimination and learning from outcomes of analysis of incidents took place. Best practice guidelines and other information were communicated through meetings although recording in this area could be more detailed to provide more evidence of items discussed and outcomes. The practice also proactively sought patient's feedback and engaged patients in the delivery of the service and acted on any concerns raised by both patients and staff.

The GPs were involved in revalidation, appraisal schemes and continuing professional development. The GPs had learnt from incidents and complaints and recognised the need to address future challenges. This included succession planning and future developments working with the local commissioning group. The GPs told us good study time and budgets were available for training. They also said the provider funded a leadership training programme which they had found valuable.

Leadership, openness and transparency

The staff told us there was a relaxed atmosphere in the practice and there were opportunities for staff to meet for discussion or to seek support and advice from colleagues. Staff were complimentary about the management of the practice and said they had been well supported.

The practice held regular staff meetings. The staff told us there was an open culture within the practice and they said they had the opportunity and were happy to raise issues at team meetings. The staff also told us they had protected learning time and felt supported in their learning and career objectives.

We reviewed a number of policies, including recruitment and selection, disciplinary procedures and whistleblowing procedures, which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received.

They displayed a "Question of the month" in the surgery and patients were invited to comment on a particular aspect of the service. For example, in June they had asked patients for their feedback on the new appointment system and had received positive responses.

The practice also made the friends and family test available to patient's in the waiting room although the results of this were not displayed. We saw the results from January 2015 to June 2015 were positive. From 403 responses, 81.14% said they would recommend the practice to family and friends.

The practice had identified that they could improve engagement with patients. The practice promoted their patient participation group (PPG) however they said they had found patients were not very responsive. Their 2015 PPG report stated they had three members. This report also identified points for action following a patient survey. One point raised in the survey was the lack of a female GP and this had been addressed. The PPG was the topic for July's question of the month.

Staff felt they were engaged with the development of the service and they said they could raise ideas or concerns at their meetings.

Management lead through learning and improvement

Are services well-led?

Good

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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and offered opportunities for development.

The practice completed reviews of performance data, significant events and complaints and shared this information with staff at meetings to ensure the practice improved outcomes for patients.