Dr Shahid Amin

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Shahid Amin (St Luke's Surgery) on 30 June 2016. The overall rating for this practice is good.

Our key findings were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events, and we saw evidence that learning was applied from events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was a robust staff appraisal system, and individuals were encouraged and supported to develop in their roles.
- Feedback from patients about their care, and their interactions with all of the practice staff, was positive. Patients said they were treated with compassion, dignity and respect and most said that they were involved in their care and decisions about their treatment.
- We received some mixed views with regards the practice appointment system. However, most patients said they found it easy to book an appointment with a GP. We observed that the appointment system was flexible and responsive to patients' needs. Urgent appointments were available the same day.
- Access to the practice nurse was limited to mornings and early afternoon. Appointments were therefore not available outside of school hours for children, and this potentially created some difficulties for working parents. There was no designated cover for the practice nurse during periods of leave.
- The practice used clinical audits to review patient care and we observed how outcomes had been used to enhance quality care and improve service provision.
- The practice worked effectively with the wider multi-disciplinary team to plan and deliver effective and responsive care to keep vulnerable patients safe.
- There was strong and visible clinical and managerial leadership, supported by clear governance arrangements within the practice. Staff told us that they felt well-supported by management and enjoyed their work.

Summary of findings

- The practice had good facilities and was well-equipped to treat patients and meet their needs. The premises were clean, tidy and well-organised.
- Information about how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concern.
- The surgery had an active patient participation group (PPG) which influenced changes within the practice. For example, the practice had re-worded the letter sent to patients who did not attend for their allocated appointment, in order to make it read more sensitively.
- The practice proactively sought patient feedback and reviewed the way it delivered services as a consequence of this.

The areas where the provider should make improvement are:

- Implement an auditable procedure for the receipt, distribution and actioning of alerts received via the Medicines Health and Regulatory Authority (MHRA), and for the receipt and acknowledgement of new guidance.
- Continue to take steps to improve outcomes for patients where Quality and Outcomes Framework (QOF) achievement is lower.
- Ensure a procedure is in place to monitor and action any uncollected prescriptions, and a sign-out procedure is in place to monitor the collection of prescriptions for controlled medicines.
- Review the availability of practice nurse hours.
- Strengthen the infection control lead role by defining key responsibilities, and ensuring additional training is undertaken to support this role.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

- There was an effective system in place for reporting and recording significant events. Staff were encouraged and supported to report incidents via an open 'no blame' culture. Lessons were shared to make sure actions were taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, people received support, information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Site-related health and safety risks to patients and the public were assessed and well-managed including procedures for fire safety and legionella.
- Medicines, including vaccines and emergency medicines, were stored safely with good systems to monitor and control stock levels.
- Uncollected prescriptions were not followed up with patients to ensure they were taking their prescribed medicines appropriately. There was not a clear process for signatures to be recorded when collecting prescriptions for controlled medicines from the practice reception.
- Whilst we observed that alerts received from the MHRA were dealt with to keep patients safe, the practice did not have an auditable process or a defined protocol to support this.
- The practice had effective systems in place to deal with medical emergencies.

Are services effective?

Good

- Data showed patient outcomes were slightly below local and national averages. The practice had achieved an overall figure of 85.7% for the Quality and Outcomes Framework (QOF) in 2014-15. This was below the CCG average of 91.4% and the national average of 94.7%. However, the practice highlighted the difficulties they experienced in terms of patient engagement and could demonstrate how they continually strived to address this.
- Clinical audits were used to review performance and enhance quality improvement.

Summary of findings

- The associate GPs provided an additional dimension that impacted upon quality, including expertise in mental health and data analysis.
- The practice had developed the functionality of their computer system to benefit patient care. For example, additional prompts helped in the early detection of some conditions.
- Staff had the skills, knowledge and experience to deliver effective care and treatment in line with current evidence based guidance.
- Annual appraisals and personal development plans were in place for staff. We saw good examples of documentation and evidence of clear objectives and the identification of appropriate training needs.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs, in order to deliver care more effectively. Monthly meetings with wider members of the healthcare team were held to review more complex and vulnerable patients.
- The practice had high attendances at Accident & Emergency (A&E). The GPs were able to explain the reasons for this, and how they were trying to educate their patients appropriately. Audit work had helped to analyse this problem.
- A GP had developed templates to assist in the early detection of bowel cancer. These templates helped identify patients with risk factors and prompted GPs to ask particular questions in support of the assessment. These templates had been incorporated onto the clinical computer system nationally to benefit wider patient care.

Are services caring?

Good

- The practice ethos of addressing health inequalities was pivotal to their work. We saw examples of how the practice cared for patients with histories of complex problems that could be difficult to manage. The practice had a policy of not removing patients (for example, those with behavioural problems) from their list, in recognition of their need to gain access to health care.
- The latest national GP Patient Survey results showed that patients rated the practice either in line or slightly below CCG and national averages in respect of care. For example, 87% of patients said that the GP was good at giving them enough time which matched local and national averages. However, 74% of patients said the last GP they saw GP was good at explaining tests and treatments compared against a CCG and national average of 86%,

Summary of findings

- Patients we spoke with during the inspection and feedback on our comments cards indicated they were mostly treated with compassion, dignity and respect and generally felt involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. Signposting information was provided for those with a caring responsibility.
- The practice had identified 4% of their list as being carers which was higher than local averages, although this was being reviewed for accuracy. Carers were signposted to services for support.
- We observed that staff treated patients with kindness and respect, and maintained confidentiality.
- Views of external stakeholders were positive in respect of the high level of care provided by the practice team.

Are services responsive to people's needs?

Good

- Patients had to contact the surgery at 8.15am each morning to make an appointment with the GP on the day. The practice provided an online appointment booking facility although only 5% of appointments were available as part of this.
- Urgent appointments were available on the day. Telephone consultations were available each day so that patients could speak with a GP, rather than attending the practice for a face to face consultation.
- Patients could order repeat prescriptions online. The practice participated in the electronic prescribing scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- Comment cards and patients we spoke to during the inspection raised mixed responses about their experience in obtaining both urgent and routine appointments. The national GP survey in January 2016 found 77% of patients were able to get an appointment or speak to someone the last time they tried (compared to a local average of 83% and national average of 85%). However, 74% of patients described their experience of making an appointment as good in line with the CCG average of 74% and national average of 73%.
- The practice had good facilities and was well-equipped to treat patients. It had reasonable access for patients with a disability,

Summary of findings

and had been assessed by the 'disabled go' network as being accessible and friendly to people with a disability. However, we observed that a patient using a wheelchair encountered some difficulties negotiating obstacles and doorways.

- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff to improve the quality of service.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients.

Are services well-led?

Good

- The practice had developed clear values and a mission statement. This was supported by aims and objectives to deliver high quality care and promote inclusivity with good outcomes for patients.
- The practice had formulated a draft business plan. This was to be discussed with the team to ensure they had ownership and were empowered to contribute towards future planning arrangements.
- There was a strong and clear leadership structure, and staff told us that they were supported by the management.
- The practice worked with other practices in the health centre, and attended meetings and events organised by their CCG. The practice was participating in a local GP alliance which offered some opportunities for future developments via a more collaborative and co-ordinated approach.
- The practice held regular meetings to discuss clinical issues, and general staff meetings were arranged for wider issues. Staff could propose items for discussion at the meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The practice had developed policies and procedures to govern activity.
- The practice sought feedback from staff and patients, which it acted on. It had a positive relationship with the PPG which helped to shape practice development.
- There was a strong focus on continuous learning and improvement at all levels, and we saw examples of innovative 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

Good

- The practice had lower percentages of registered older people with 9.9% of patients aged 65 and over (local average 11.1%; national average 17.1%).
- Patients were assessed using a validated tool to determine if a referral was required to the memory clinic. This assessment was used as an opportunity to also assess the patient's carer and to signpost them to any support that may be required.
- The practice ensured patients received appropriate support for their needs and referred individuals to the Nottingham City Signposting Service. This service was aimed at people aged 60 and over and aimed to promote independence, safety and security by providing access to a range of local support services.
- A care co-ordinator worked closely with the practice and facilitated referrals to other services including the falls team, carers' assessments, and social services.
- The community consultant for health care of the elderly provided the practice with advice and support on any complex care needs.
- Monthly multi-disciplinary meetings were held to review frail patients and deliver care appropriate to their needs. However, we did not see a clear overview of unplanned admission data being utilised to influence these discussions.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those who needed them. Longer appointments could be booked if these were required.
- Flu vaccination rates for the over 65s were 63% which was lower than the local average of 72.9% and the national figure of 73.2%.

People with long term conditions

Good

- Data showed patient outcomes were generally in line with averages for the locality. The practice had achieved an overall figure of 85.7% for the Quality and Outcomes Framework (QOF) in 2014-15. This was 5.7% below the CCG average, and 9% below the national average. QOF performance was monitored via clinical staff meetings, and actions were agreed to continually improve achievements.

Summary of findings

- Performance for diabetes related indicators at 66.6% was below the CCG average of 79.1% and the national average of 89.2%. However, the level of exception reporting for diabetes patients was noted to be lower than local and national averages. The practice reviewed their achievement regularly and agreed measures to enhance their performance.
- QOF indicators for chronic obstructive pulmonary disease (COPD) achieved 92.8% and this was broadly in line with CCG and national averages (95.4% and 96% respectively).
- All patients with a long-term condition received a structured annual review to check their health and medicines needs were being appropriately met. For example 80% of patients on the practice diabetes register had received a review in the last 15 months. Designated staff members co-ordinated the reviews and followed up patients who did not attend.
- The practice held monthly multi-disciplinary meetings to review those patients with more complex needs and associated risk of hospital admission. The practice team worked closely with other local providers including the community matron, district nursing team and social services to deliver multidisciplinary packages of care.
- A health care assistant provided a weekly clinic to ensure blood tests were taken in order for the practice to monitor high risk medicines, and patients being seen as part of a shared care arrangement with the hospital consultant.
- The practice had added alerts into their computer system to ensure urgent same day appointments would be provided for high risk patients.

Families, children and young people

Good

- A baby clinic was provided within the health centre and the practice would accommodate any requests for a GP appointment by those attending the clinic on the same day.
- Appointments with the practice nurse were limited to mornings and early afternoon. This meant that appointments were not available outside of school hours.
- The premises were suitable for children and babies. Baby changing facilities were available and the practice accommodated young mothers who wished to breastfeed.
- The practice held quarterly meetings with the health visitor to review any children on a child protection plan or deemed to be at risk.

Summary of findings

- The practice provided post-natal checks for new mothers and eight week baby checks, and there was system in place to refer patients into ante-natal care and support.
- The practice had been accredited as part of the 'You're Welcome' programme to support the provision of young people friendly health services. Staff had received training to support this. Patients aged 13 and over could be seen by a GP or nurse either alone or with a friend, in the strictest of confidence. Young patients were sent birthday packages when they reached 13 that included information on the practice and its services, specifically those aimed at younger patients.
- The practice were supporting a CCG led initiative '15 steps for young people' which helped identify younger people's perception of health care and aimed to help identify their needs to make services more accessible to them. Questionnaires were due to be distributed the week after our inspection.
- The practice supported sexual health for young people and supported the c-card scheme which provided a free condom distribution service and advice for people aged 13-25. Chlamydia screening was available upon request.
- The practice nurse provided contraception clinics and advice, and patients were referred into a local family planning clinic for services such as coil and implant fittings and removals.
- Vaccination rates were slightly below local averages for standard childhood immunisations. For example, vaccination rates for children at two years old ranged from 84.1% to 96% compared against a CCG average ranging from 91.1% to 96.3%. The practice team monitored uptake of childhood vaccinations to enable those who did not attend to be followed up by the health visitor.

Working age people (including those recently retired and students)

Good

- Feedback from patients we spoke with was mixed about their experience in obtaining an appointment quickly and a time that was convenient to them.
- There were no extended hours' consultation times provided at the time of our inspection. This service had previously been available on a Monday evening but had been stopped with a review planned for April 2017.

Summary of findings

- Patients could book appointments online although these were limited to 5% of the total appointments available. Telephone consultations were available each day for those patients who had difficulty attending the practice due, for example, to work commitments.
- The practice offered online services to order repeat prescriptions. The practice also undertook electronic prescribing so that prescriptions could be sent directly to the pharmacy of the patient's choice.
- Health promotion and screening was provided that reflected the needs for this age group. NHS health checks were undertaken by a health care assistant and any patients requiring follow up were seen by the GP to implement the necessary care package.
- The practice's uptake for the cervical screening programme was 69.3% which was below the CCG average of 81.3% and the national average of 81.8%. The practice was targeting ways to improve their uptake rates.

People whose circumstances may make them vulnerable

Good

- All vulnerable patients were identified at the registration process and via the new patient health check. Alerts were added to the patients' records and plans for any follow up care or support would be arranged.
- The practice registered refugees referred by the local refugee forum. These patients received a new patient health check, and any children were booked an initial appointment with the GP. Practice staff had received training about asylum seekers.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Homeless people could register with the practice.
- The practice worked with multi-disciplinary teams in the case management of vulnerable people and informed patients 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.
- The practice provided support for end of life patients and kept them under review in conjunction with the wider

multi-disciplinary team. No audit information was available to determine if patients' needs and wishes had been fulfilled including if they had died in their preferred place.

- The practice had undertaken an annual health review for 66% of patients with a learning disability in the last 12 months. Support tools designed for ease of communication with learning disability patients were used to facilitate the review, which provided a holistic assessment of each person's individual needs. The practice worked with the local learning disabilities nurse facilitator, and training had been provided to staff to raise their awareness of learning disabilities.
- Longer appointments were available for people with a learning disability or others whose needs indicated this was required.
- There was a carers identification scheme with referral to support services when required.

People experiencing poor mental health (including people with dementia)

Good

- The practice had one of the highest rates of significant mental health problems (2%) within their CCG. Staff worked hard to meet the needs of these patients and upheld an ethos of ensuring services were accessible to them. For example, the practice did not remove patients from their list if they had been subject to challenging behaviour.
- The practice tailored services to accommodate patients' needs, for example, dedicated clinics were provided to help improve physical care for patients with significant mental health illnesses. Further to a recent baseline audit, an action plan had been developed to promote healthier lifestyles and improve access to health screening services.
- The practice achieved 68.7% for mental health related indicators in QOF, which was 20% below the CCG and 24% below the national averages. However, exception reporting rates were approximately one third of the local and national averages.
- 65.2% of patients on the practice's mental health register had received an annual health check during 2014-15. This was below the CCG and England averages (83.3% and 88.4% respectively), but there were much lower rates of exception reporting at 4.1% (compared to 11.1% and 12.6% locally and nationally).

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- 70% of people diagnosed with dementia had had their care reviewed in a face to face meeting during 2014-15. This was approximately 14% lower than local and national averages. However, no patients were exception reported within this indicator.
- The practice worked with multi-disciplinary teams in the management of people experiencing poor mental health, including those with dementia. This included the mental health crisis team to ensure those patients experiencing acute difficulties received urgent assistance to manage their condition.
- The practice told patients experiencing poor mental health and patients with dementia about how to access services including talking therapies and various support groups and voluntary organisations. Information was available for patients in the waiting area.
- The practice undertook reflective learning following significant events when patients had ended their own lives, and had collaborated with other practices to peer review attempted suicides to share learning outcomes.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line than local and national averages. 395 survey forms were distributed and 106 were returned, which was equivalent to a 27% completion rate.

- 74% of patients found it easy to get through to this surgery by phone in line with the CCG average of 74% and the national average of 73%.
- 88% of patients found the receptionists at this surgery helpful in line with the CCG average of 89% and the national average of 87%.
- 77% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 83% and a national average of 85%.
- 97% of patients said the last appointment they got was convenient compared to a CCG average of 92% and a national average of 92%.
- 74% of patients described their experience of making an appointment as good in line with the CCG average of 74% and the national average of 73%.
- 64% of patients usually got to see or speak to their preferred GP compared to a CCG average of 59% and a national average of 59%.

As part of our inspection we received 53 CQC comment cards which had been completed by patients prior to our inspection. Forty-seven (88.6%) of the comment cards were positive about the high standards received, and many praised individual GPs and the nurse for the quality of care received. Eight comment cards (15%) raised a negative patient experience in obtaining a GP appointment, although five of these also included reference to being satisfied with the service generally. Three other cards (5%) contained negative comments relating to patient experience of the service, or their interaction with staff members.

We spoke with six patients during the inspection. All six patients said that they were generally satisfied with the care they had received and that they were usually able to get to see their preferred GP. Two of the patients stated that access to appointments could sometimes be difficult, whilst the other patients told us that they were always able to get an appointment when they needed to see a GP. The majority of feedback from the six patients indicated that patients felt they were treated with dignity and respect, and we were told that clinicians gave enough time to explain treatment options and the purpose of any prescribed medicines.

Dr Shahid Amin

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 an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr Shahid Amin

Dr Shahid Amin, also known at St Luke's Surgery, is situated in an inner city area just outside of the city centre of Nottingham. The practice operates from the lower ground floor within a purpose-built health centre building owned by NHS Property Services and managed by the local community health Trust. The health centre accommodates four general practices and a range of community based health services.

The practice is run by a male GP working with two part-time GP associates (one male and one female). The practice also has regular sessional input from two locum GPs. The practice employs a part-time practice nurse and part-time health care assistant. The clinical team is supported by a part-time practice manager and part-time finance manager, plus a team of team of four part-time administrative and reception staff. The practice also employs an apprentice receptionist.

The registered list size of 3,879 comprises of a diverse and multi-cultural population including a high percentage of Polish, Indian and Pakistani patients. The practice is ranked in the second most deprived decile, and has much higher income deprivation scales affecting children and older people than national figures. For example, income deprivation affecting older people is 41% compared against a national average of 16%). The practice age profile has slightly higher percentages of patients aged 20-40 years old. The percentage of patients aged under 25 is in line with the national average, whilst there are lower percentages of patients aged over 60 registered with the practice.

The practice opens from 8.15am until 6.30pm Monday to Friday, apart from Thursday when the practice closes at 12.30pm. The practice also closes one afternoon each month for training purposes. GP morning appointments times are available from 9am to approximately 12 noon, and afternoon surgeries run from 3.40pm to 6pm. The practice does not currently provide any extended hours GP and nurse surgeries.

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed, patients are directed to NEMS via the 111 service.

The surgery provides primary care medical services via a General Medical Services (GMS) contract commissioned by NHS England, and services commissioned by NHS Nottingham City Clinical Commissioning Group (CCG).

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS Nottingham City CCG to share what they knew.

We carried out an announced inspection on 30 June 2016 and during our inspection:

- We spoke with staff including GPs, the practice and finance managers, the practice nurse and healthcare assistant, and a number of reception and administrative staff. In addition, we spoke with a district nurse and health visitor regarding their experience of working with the practice team. We spoke with six patients who used the service, and two representatives from the practice patient participation group.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 53 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. There was a recording form available on the practice's computer system, and the staff member involved in the incident would complete the form and then send it to the practice manager. Staff were supported to complete the form if this was required.

The practice carried out a thorough analysis of significant events and discussed these at bi-monthly meetings with the practice team. The meetings were well-documented and showed the events were reviewed with an open and reflective approach. A total of 24 significant events had been recorded over the last 12 months, demonstrating a proactive approach to incident reporting. Positive events were also reported to celebrate success and share best practice. We saw that learning had been applied when unintended errors or events had occurred. For example, the practice told us about an incident in which a patient presented with symptoms requiring urgent attention. The team responded swiftly but calmly and moved the patient into a consulting room away from other patients. The patient was then cared for and monitored until they could be transferred to the hospital by ambulance. The practice was able to reflect on the good care provided, but also identified that a portable manual blood pressure machine would have been useful in this situation, and subsequently purchased one. This demonstrated how learning was applied to benefit care for patients in the future.

When there were unintended or unexpected safety incidents, people received support, information and an apology, and were told about any actions to improve processes to prevent the same thing happening again. We saw an example of this which demonstrated the GP's commitment to the patient's care and safety, and responsibilities as part of the duty of candour. This incident was followed up effectively and promptly, and the patient received immediate and comprehensive support and care.

The practice had recently identified that their response to information received from the Medicines and Healthcare Regulatory Agency (MHRA) required a new approach. Whilst GPs responded to alerts by checking patients' medicines and taking action to ensure they were safe, there was no clear protocol and the process could not be audited to provide evidence of what had been done. The practice had undertaken a significant event review when this had been identified to them prior to our inspection, and the practice was in the process of developing a clear and robust methodology for when MHRA alerts were received in the future.

Overview of safety systems and processes

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding, with the appropriate safeguarding training at level 3. Quarterly meetings took place between the GP safeguarding lead and members of the practice team with the health visitor to discuss any vulnerable children. These meetings were documented, and the patients' notes were updated during the meeting. Alerts were used on the system to identify any vulnerable children to ensure all staff were aware of the need to identify any new concerns. The health visitor attended the practice regularly which enhanced communication with regards to any ongoing concerns. Staff demonstrated they understood their responsibilities for safeguarding and all had received training relevant to their role.
- A notice in the waiting room advised patients that staff would act as chaperones if required. Reception staff undertook chaperoning duties and had completed training to support them in this role. All staff who acted as chaperones had received a disclosure and barring check (DBS check). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice had developed a concise chaperone policy to support this aspect of their work.
- We observed the practice to be clean and maintained to a high standard. The practice nurse was the identified infection control lead, although no additional training had been completed to support this role. The practice had not developed clearly defined responsibilities for this role, although this was something which they addressed immediately following our inspection. There were a range of comprehensive infection control policies in place and practice staff had received training

including hand-washing. The practice had established links with the local infection prevention and control team who undertook a bi-annual audit at the practice. We saw evidence that action had been taken to address improvements identified as a result. The practice nurse had modified a template to undertake the practice's own infection control audits and we saw a recent example of this, including actions identified from the audit. The practice's cleaning arrangements were organised through the landlord who had developed cleaning schedules with regular monitoring arrangements to ensure high standards were maintained. There was regular liaison between the site management and practice manager to ensure good communication on any issues relating to cleaning services.

- We saw evidence that staff had received vaccinations to protect them against hepatitis B.
- We observed a robust procedure was in place to review and take action for all incoming correspondence. This ensured that patients' needs were responded to promptly and kept them safe.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice kept patients safe. Blank prescriptions were securely stored and there were systems in place to monitor their use. Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and there was a system for the production of Patient Specific Directions to enable health care assistants to administer specific medicines such as flu vaccinations.
- Patients prescribed high risk medicines were kept under regular review by the practice. There was not a clear system in place to follow up any patients who did not collect their prescriptions, nor a sign-out procedure in place to monitor the collection of controlled drug prescriptions.
- 84% of patients on repeat medicines had received a review of the prescribed medicines in the last 15 months.
- We reviewed five personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There was a health and safety policy available and there were procedures in place for monitoring and managing risks to patient and staff safety. The practice had an up to date fire risk assessment (April 2016) and carried out regular fire training including trial evacuations. All electrical equipment had been checked to ensure it was safe to use and clinical equipment was validated to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as the control of substances hazardous to health; lone working arrangements; and the use of wheelchairs. A formal risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings) had been completed and was kept under review.
- Arrangements were in place to plan and monitor the number of staff and mix of staff needed to meet patients' needs. There was flexibility within the reception and administrative team to provide cover for staff on leave. However, we observed that the available nursing and health care assistant hours limited options for patients to attend the practice at different times during the day. There was no routine cover for nursing hours during periods of leave or sickness and this had the potential to impact on service continuity for patients. The senior GP took lead responsibility in all areas as the other GPs were either associates or locums. This included responsibility to provide home visits and administrative duties in addition to their clinical workload. The practice was actively trying to recruit a second partner to address this situation, and alleviate some of the pressures on the senior GP.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers and an audible alarm in all the consultation and treatment rooms and reception, which alerted staff to any emergency.
- All staff had received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.

Good

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- The practice had an up-to-date business continuity plan in place for major incidents such as power failure or building damage. A copy of the plan was kept off site in case access to the premises was not possible, and buddy arrangements had been considered with nearby practices. The plan had been reviewed in December 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) guidelines, and local guidance, for example, in relation to prescribing. However, there was not a clear process to demonstrate evidence of how this was cascaded, discussed, actioned and reviewed by the practice team.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recently published results showed the practice had achieved 85.7% of the total number of points available (compared against a CCG average of 91.4% and a national average of 94.7%), with an exception reporting rate of 5.4% which was below local and national averages. The exception reporting rate is the number of patients which are excluded by the practice when calculating achievement within QOF. QOF performance was monitored via regular clinical meetings, and actions were taken to improve achievement where this was possible.

- Performance for diabetes related indicators at 66.6% was below the CCG average of 79.1% and the national average of 89.2%.
- The percentage of patients with hypertension having regular blood pressure tests at 80.5% was broadly in line with the CCG average of 82.6%, and the national average of 83.6%.
- The achievement for mental health related indicators at 68.7% was below the CCG average of 88.7% and the national average of 92.8%
- The percentage of patients with chronic obstructive airways disease who had received an assessment of their breathing in the previous 12 months was 83.6% which was 5.2% lower than the local average and 6.2% below the national average.
- Exception reporting rates were mainly lower than local and national averages demonstrating that the practice tried to engage patients in having their condition reviewed regularly. Rates were however higher for depression, heart failure and chronic kidney disease. We were assured that the exception reporting was appropriate and justified.

Clinical audits demonstrated quality improvement:

- There had been six clinical audits undertaken in the last year and three of these were completed full clinical audit cycles where the improvements made were implemented and monitored.
- Findings from audits were used by the practice to improve services. For example, an audit was undertaken of patients with a raised systolic hypertension (this is a high reading of one of the two measures taken to determine a patient's blood pressure). This audit identified 28 patients without a formal diagnosis of hypertension. An alert was then set up on the system for clinicians to keep this under review when they saw the patient. Outcomes demonstrated that coding was used to identify this cohort of patients; patients were kept under regular review; and blood pressure monitoring was undertaken including 24 hour monitoring of blood pressure to allow the opportunity to adjust medicines accurately.
- One GP was also the Associate Medical Director for the local mental health Trust. This role benefited the work of the practice. For example, this GP had just undertaken a baseline audit on the physical health status of patients with severe enduring mental health. This was undertaken in response to the high numbers of registered patients with significant mental health problems. Lifestyles and reduced interventions for preventative healthcare in this group of patients are known to have an adverse effect on life expectancy. The audit resulted in the development of an action plan that included targeting smokers with additional specialist help, and increasing the uptake of cancer screening services. Plans were in place to review this later in the year to assess outcomes.
- The practice had been identified as an outlier in terms of mortality rates. An audit had been undertaken to review patient deaths and whilst this identified that high quality care had been delivered, some learning points were identified to enhance future care provision. The mortality rates had since been demonstrated to be marginally below the local average.

Good

Are services effective?

(for example, treatment is effective)

- The practice carried out 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. The practice utilised prescribing data to review any areas in which they may show as being an outlier in comparison to other practices or available guidance. We saw examples of this including on ongoing review on the prescribing of a particular antibiotic medicine. An audit had been completed with the subsequent development of a corresponding action plan, which was due for review in autumn 2016.

Effective staffing

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The two associate GPs contributed to the delivery of a quality service by their areas of expertise. For example, one of the associates was employed by the university and assisted the practice to participate in research projects, some of which had made significant impacts on patient care. This included an early identification of patients with a specific cancer to enable them to access care more promptly, and thereby achieve better outcomes. This work had led to the refinement of templates used during consultations to help identify risk. This had since been rolled out to all practices across the country using the same computer software system.
- The practice held a bi-monthly GP clinical meeting and a quarterly clinical team meeting to review any clinical matters. For example, the quarterly meeting had been used for the whole team to review cervical screening uptake and QOF performance.
- We saw evidence of completed induction programmes for newly appointed members of staff that covered such topics as safeguarding, health and safety, and confidentiality. Staff informed us how they had received good support when they started their job with opportunities to shadow and learn from others.
- The learning needs of staff were identified through an appraisal system which we observed was robust and up to date. The practice manager regularly reviewed progress with objectives, and most members of staff received a quarterly review. The appraisal was used to identify training needs and the practice supported their staff to develop in their roles. For example, the health care assistant had been supported to learn new skills including health check reviews of patients with a learning disability, prior to seeing the GP for their annual review. Further training including spirometry (a test to check lung function) was planned. Reception and administrative staff had been supported to undertake NVQ training.
- Practice staff had access to e-learning training modules and other learning opportunities in addition to in-house training. Staff had received up-to-date mandatory training that included safeguarding, fire procedures and basic life support.
- The lead GP provided ongoing mentorship and support for the nurse and health care assistant.
- The practice ensured role-specific training with updates was undertaken. For example, the practice nurse in administering child vaccinations and taking samples for the cervical screening programme.
- The practice was reviewing their skill mix arrangements being mindful of how the service would need to adapt in the future. For example, a member of the administrative team was undertaking some training to provide additional health care assistant support.

Coordinating patient care and information sharing

The practice team worked collaboratively with other health and social care professionals to assess the range and complexity of patients' needs and plan ongoing care and treatment. Monthly meetings took place with representation from a wide range of professionals including the district nurse, the community matron, and care co-ordinator. Others including social services, the Macmillan nurse, and specialist nurses were invited when relevant patients were to be discussed. This provided an opportunity to review vulnerable adults, end of life patients, patients with a long-term condition, and those at higher risk of a hospital admission. These meetings were documented with any agreed actions being recorded. Meeting dates were arranged a year in advance so that all attendees had the opportunity to schedule these into their diaries.

We observed examples of care plans and the effective use of computer templates to ensure the patient's history and current health needs were clear and accessible.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

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

Health promotion and prevention

The practice provided a range of support to promote healthier lifestyles and referred patients into services for smoking cessation and weight management advice.

The practice's uptake for the cervical screening programme was 69.3% which was significantly below the CCG average of 81.3% and the national average of 81.8%. The practice had employed great efforts to improve on this and reviewed progress at regular meetings. This included telephoning patients by someone who was able to speak in the patient's own language; translation of letters inviting women for screening; and proactively discussing the issue with patients to stress the importance of being reviewed. These measures were having a gradual impact and numbers were slowly increasing. The practice uptake for bowel and breast cancer screening was significantly lower than CCG average and national averages which the practice were working to address. This included involvement in a pilot scheme to actively target those who had not attended with a follow up letter, and additionally the practice were telephoning patients to encourage uptake.

The practice had a robust process in place to refer patients with suspected cancer under the two-week wait referral to see a specialist. Systems had been reviewed further to a significant event review following a delayed referral, and we observed that the procedure in place was reliable and effective.

Childhood immunisation rates were comparable to local CCG averages. For example, childhood immunisation rates for the vaccinations given to infants up to two year olds ranged from 84.1% to 96% (compared against 91.1% to 96.3%); and five year olds from 81.3% to 91.7% (compared against 86.9% to 95.4%). Uptake of immunisations was monitored and if patients did not attend on three occasions, the health visitor would be informed to follow this up. Alerts were added to the record to see if immunisations could be encouraged if the patient attended the practice for another consultation. The practice wished to increase the uptake of immunisations further and had contacted a nearby practice with higher immunisation rates to look at sharing best practice.

Flu vaccination rates for the over 65s were 63% compared to a national average of 73.24%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Any issues that were identified requiring further review were passed onto the GP for attention.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

The practice had a long history of caring for vulnerable patients, for example, those with significant mental illnesses and drug and alcohol problems. It was committed to carry this on and did not remove patients from their list, even where this had posed difficulties in respect of their ongoing management, for example, patients displaying confrontational behaviour.

We observed that members of staff were courteous and helpful to patients and treated people dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments.
- We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could relocate into a free consulting room or quiet area to discuss their needs. A radio was used to try and reduce conversations being overheard in the waiting area.

We received 53 completed patient CQC comment cards, and the vast majority of these were positive about the standards of care experienced. Patients said that staff were caring and treated them with dignity and respect.

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

- 84% of patients said the last GP they saw was good at listening to them compared to the CCG average of 87% and the national average of 89%.
- 87% of patients said the GP gave them enough time in line with the CCG and national averages of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%.
- 78% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national averages of 85%.
- 82% of patients said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Care planning and involvement in decisions about care and treatment

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

- 74% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 73% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.

However, comment cards and patients we spoke to during the inspection indicated that patients mainly felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations.

Patient and carer support to cope emotionally with care and treatment

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives and carers.

Notices in the patient waiting room told patients how to access a number of support groups and organisations, and a wide range of literature was available for patients.

The practice's computer system alerted GPs if a patient was also a carer. Information was available to direct carers to support services available to them. The practice had identified 148 carers which equated to approximately 4% of the practice list as carers, and identified new carers upon registration. A carers' lead had been identified within the practice, and a carers protocol was being finalised for the practice. There was an active local carers' support group and this group were due to attend the practice to provide some training for staff.

Good

Are services caring?

The GP usually contacted bereaved relatives by telephone when there had been significant involvement from the doctor, and additional support was offered to support them if this was indicated.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- There was a proactive approach to understanding the needs of different groups of people to deliver care in a way that met their needs and promoted equality. This included people in vulnerable circumstances with complex needs.
- The practice did not offer extended hours GP and nurse appointments at the time of our inspection. These had previously been available but had been withdrawn in April 2016 due to capacity issues. The practice intended to review the situation in April 2017 with the aspiration that a GP partner may be recruited.
- Longer appointments were available for patients for patients with complex needs. Home visits were provided for patients who were frail or housebound.
- The practice served a diverse and transient population. It had been identified that patients spoke a total of 38 different languages. Members of the practice team spoke Polish, Urdu and Punjabi which proved to be an asset in dealing with their patients. Interpreter services were available for patients who needed them, and these were used on a regular basis, both in person and via the telephone.
- A 'drop-in' baby clinic was available in the health centre on one morning each week. The practice ensured any infants attending this clinic who needed to see the GP were seen the same day.
- The practice used equipment to photograph skin problems and send images to hospital dermatology consultants. This helped to reduce the requirement for patients to travel to hospital, and expedite access to treatment should this be indicated.
- The premises provided disabled access with automatic entrance doors, although we observed that wheelchair manoeuvres could be difficult in some areas. The practice had a portable loop to help those with hearing difficulties.
- The practice provided rooms for patients to consult with other professionals. For example, the community paediatrician and dietician had designated rooms within the practice.
- The health centre hosted a number of services on site which improved local access for practice patients. This included ultrasound services; smoking cessation services; and family planning clinics.
- A television screen in the waiting area provided information for patients.

Access to the service

The practice opened between 8.15am and 6.30pm Monday to Friday, except on Thursdays when the practice closed at 12.30pm. The practice also closed on one Tuesday afternoon each month for staff training. GP appointments times varied slightly each day, due to which GPs were on duty. Appointments to see a GP were generally available each morning from 9am until approximately 12 noon. In the afternoons, GP surgeries ran from approximately 3.40pm to 6pm. The practice did not currently provide any extended hours GP and nurse surgeries, although appointments had previously been available on a Monday evening until the end of March 2016. The practice had stopped these due to capacity issues, but intended to review this in April 2017 when they hoped to have recruited additional GP hours.

Patients were told to ring the surgery at 8.15am to access slots which has been embargoed. Pre-bookable appointments could be booked up to one month in advance. Urgent appointments and telephone appointments were available on the day for people that needed them, including children attending the baby clinic on site. On the day of our inspection, we observed that the next bookable routine GP appointment by telephone or in person was available in two weeks' time, although some earlier appointments could be booked on line.

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

- 74% of patients said they could get through easily to the surgery by phone in line with the CCG average of 74% and national average of 73%.
- 74% of patients described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 59% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61% and national average of 65%.

The practice had identified that there was scope for improvement with their telephone system and had considered a queuing system being introduced to alleviate pressures through to the surgery in the early morning.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We observed that the practice's rate of patient attendances at the A&E department was the fifth highest of 57 practices in the CCG at 325 patients per thousand population compared to the CCG average of approximately 300. The practice was aware of this issue and staff were making great efforts to educate patients in the correct use of this service. The rates of A&E attendance had decreased slightly in comparison to previous years, demonstrating that the measures taken by the practice were having some impact.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled the complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

We looked at 14 complaints received in the last 12 months and found these were satisfactorily handle and dealt with in a timely way in an open and transparent manner. All complaints were reviewed to ensure lessons were learnt, and action was taken to as a result to improve the quality of care. For example, the practice implemented a coding system to record sensitivities to particular medicines as an allergy on the patients' records. This was undertaken as the computer did not alert a previously identified sensitivity to a medicine and this was subsequently prescribed to the patient. The recording of this problem as an allergy ensured this would be highlighted during future consultations to avoid the same medicine being prescribed in the future.

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 mission statement and had a clear vision with written service aims and objectives. These were patient-centred and included reference to ongoing staff development and quality improvement.

The GPs and practice management team were finalising a three year business plan, and planned to discuss this with their team to ensure their participation within this. The plan was described as a 'living document' to highlight that this would be regularly updated and flexible to meet any emerging demands. There were no formal business meetings in place at the time of the inspection, but these were under consideration once the business plan was finalised.

The partners were mindful of the increasing expectations and demands of GP practices and had joined with others practices as part of a GP alliance. This would assist the practice to adapt more flexibly to meet new demands via a more collaborative approach, whilst also protecting their integrity as an individual practice. An example of one development taking place was the planned development of a website to share access to a range of healthcare professionals in support of practices in need of additional clinical input.

The practice had established good working relationships with the three other GP practices co-located within the health centre. This included sharing policies and clinical work including a peer review of suicides.

The practice was actively seeking a second GP partner to establish more capacity. This would enable the main GP to share some of their lead responsibilities, and provide more robust arrangements during periods of leave.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- The practice had implemented a comprehensive range of policies and these were up to date and easily accessible to all staff via the computer.
- A programme of clinical and internal audit was used to monitor quality and to make improvements
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, and these were kept under regular review.
- The practice worked with their CCG. This provided an opportunity to benchmark the practice and gain a comprehensive understanding of the performance of the practice within their CCG. This ensured the practice were aware of any issues that they may have to address, for example cervical screening rates were noted to be lower, and the practice had taken proactive measures to try and increase uptake.
- The practice manager and GP attended bi-annual meetings with their CCG, and the practice manager attended the local practice managers meeting.
- The practice nurse was part of a network co-ordinated by a CCG practice nurse lead who provided updates, new information, and acted as a resource to share best practice and answer any queries.

Leadership, openness and transparency

The GP and practice management had the experience, capacity and capability to run the practice and ensure high quality care. The practice had recently demonstrated its resilience in adapting to change by successfully integrating a large influx of patients (many with complex health needs) following the closure of a neighbouring practice. Additionally, the practice had undergone a turbulent period in which some key staff had either re-located or retired within a similar timescale. This had been effectively managed and newly appointed staff had become established in their roles and were actively contributing to the practice's achievements.

There was a clear leadership structure in place and staff felt supported by management:

- The senior GP and practice manager were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Individual staff provided examples of how they received support, and also praise for the work they undertook.
- The practice had a finance manager which allowed financial and operational management to have their own specific focus. However, the finance manager and practice manager worked closely together to ensure the roles were complimentary.

Are services well-led?

Good

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

- Monthly practice staff meetings were held. Staff told us that there was an open culture within the practice and they felt confident and supported to raise any issues.
- Staff said they felt valued and supported by the GPs and managers in the practice. The GP and practice manager encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- A staff away day had last taken place four years ago, but another was planned for later in 2016 to provide opportunities for team building and practice development. Team members met periodically for social events.
- We observed a cohesive team who worked together effectively, and all the staff we spoke with told us that the practice was a good and enjoyable place to work.

Seeking and acting on feedback from patients and the public

- The practice encouraged and valued feedback from patients and the public. It had gathered feedback from patients through a suggestion box, patient surveys, the NHS Choices website, and via complaints received.
- The patient participation group (PPG) were active and met quarterly with the practice manager and mostly with the senior GP. The core membership of six was complimented by a virtual group of approximately 20 patients. The PPG had been proactive in bringing together PPG members from neighbouring practices to discuss some difficulties on a wider basis as part of a more collaborative approach. The PPG made suggestions to improve services for patients including opening telephone lines earlier in the morning with dedicated staffing to book appointments. The waiting room displayed information about the PPG, and details of the group were available on the practice website.
- The practice had undertaken internal patient surveys to review patient experience. One had been led by the PPG in 2014, and the practice had just completed a further survey and were about to analyse the results.
- The practice monitored monthly feedback from the Family and Friends Test (FFT). Returns for May 2016 indicated that 82.6% of patients who responded would be 'extremely likely' or 'likely' to recommend the surgery to others.

Continuous improvement

There was a focus on continuous learning and improvement within the practice. The practice team was forward thinking and proactively looked to improve outcomes for patients. For example:

- A GP had developed a Qcancer template to assist in the early detection of bowel cancer. The template helped identify patients with risk factors and prompted GPs to ask particular questions in support of the assessment. These templates had been incorporated onto the clinical computer system nationally to benefit wider patient care.
- A GP had undertaken a baseline audit on the physical health status of patients with severe enduring mental health. This was undertaken in response to the high numbers of registered patients with significant mental health problems, as lifestyles and reduced interventions for preventative healthcare in this group of patients had an adverse effect on life expectancy. The audit resulted in the development of an action plan that included targeting smokers with additional specialist help, and increasing the uptake of cancer screening services. Plans were in place to review this later in the year to assess outcomes.