Desborough Health Centre

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	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 Desborough Surgery on 20 October 2015. Overall the practice is rated as good.

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. Information about safety was recorded, monitored, appropriately reviewed and addressed although the significant event process would benefit from review.
- Risks to patients were assessed and well managed.
- 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 although some update training was overdue.
- 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 and how to complain was available and easy to understand.
- Patients' satisfaction regarding making an appointment with a GP was below average in the 2015 national survey with patients expressing dissatisfaction regarding the telephone system and difficulty in getting an appointment. However, the practice was addressing this and patients reported that they could see a GP urgently if they needed to.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.

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

Importantly the provider should :

- Review the significant event process to ensure all events are identified and recorded consistently and consider regular review.
- Ensure regular update training is completed for all staff.

Summary of findings

- Complete actions identified in the infection control audit and ensure infection control training is completed for all staff.
- Introduce a means of ensuring more privacy at reception.
- Continue work to address areas of patient dissatisfaction identified in the 2015 national patient survey.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement, although the process would benefit from review to enhance learning and sharing. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. National data showed that patients rated the practice below that of others for several aspects of care. However, patients we spoke with 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 saw that the reception area was not private and conversations could be heard if patients did not stand back whilst other patients were being attended to. We noted that staff treated patients with kindness and respect.

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. Patient satisfaction with access to appointments was mixed with some expressing difficulty, but all patients told us they could be seen if they needed an urgent appointment. The practice had good

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. 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 sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice 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

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to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks and longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had been offered an annual physical health check and the practice employed two counsellors to support patients who needed it. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed that satisfaction was below that of the local and national averages in most areas identified below. There were 113 responses and a response rate of 38.2%.

- 24.8% found it easy to get through to this surgery by phone compared with a CCG average of 71.4% and a national average of 73.3%.
- 67.6% found the receptionists at this surgery helpful compared with a CCG average of 84.9% and a national average of 86.8%.
- 49.5% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 54.7% and a national average of 60%.
- 71.5% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 85.3% and a national average of 85.2%.
- 92.6% said the last appointment they got was convenient compared with a CCG average of 92% and a national average of 91.8%.
- 44.3% described their experience of making an appointment as good compared with a CCG average of 71.9% and a national average of 73.3%.
- 59.5% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 66.6% and a national average of 64.8%.
- 51% felt they did not normally have to wait too long to be seen compared with a CCG average of 59% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were all positive about the standard of care received from clinicians but some referred to difficulty in getting an appointment, that reception staff were not always helpful and waiting times were long to see the GP once they had arrived at the surgery. Some cards commented that things had improved recently regarding appointments. We spoke with the members of the patient participation group who told us they were drafting their own survey to be carried out soon. This was to reflect the current situation as there had been changes since the last survey. They also told us they had conducted their own survey in February 2014 which showed higher satisfaction levels than that of the national survey and captured a larger number patients.

Areas for improvement

Action the service SHOULD take to improve

- Review the significant event process to ensure all events are identified and recorded consistently and consider regular review.
- Ensure regular update training is completed for all staff.
- Complete actions identified in the infection control audit and ensure infection control training is completed for all staff.
- Introduce a means of ensuring more privacy at reception.
- Continue work to address areas of patient dissatisfaction identified in the 2015 national patient survey.

Desborough Health Centre

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 advisor and a practice manager advisor.

Background to Desborough Health Centre

The Desborough Surgery is one of two locations operated by Rothwell & Desborough Health Care Group, which provides primary medical services from a two storey building, to approximately 12,000 patients in Rothwell and Desborough and surrounding areas in Kettering, Northamptonshire. Although 12,000 patients are registered specifically at this surgery, they have the option to attend the providers other surgery in Rothwell who provide services to another 8,500 patients registered there. This is registered with CQC as a separate location and therefore was not inspected as part of this process.

The practice provides primary medical services under a Personal Medical Service (PMS) agreement. There are eleven GP partners and a salaried GP, three nurse prescribers, four practice nurses, four health care assistants, a nurse manager, and a practice manager. The staff resource and services are shared over the two locations. The team are supported by a number of administrative and reception staff.

The practice population has a slightly higher than average number of patients in the over 85 years and 60 to 75 years as well as 0-10 year age group. The area does not have of a significant level of deprivation.

The practice is open between 8am and 6.30pm from Monday to Friday inclusive. When the practice is closed out of hours services are provided by Intermediate Care 24 Centre via the 111 service. The practice offers extended hours on Monday and Thursday evening from 6.30pm until 8pm and Saturdays 8am until 10.30am. These alternate between the Desborough and the Rothwell surgery.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

- 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)

Before inspecting the practice, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 October 2015. During our inspection we spoke with a range of staff, including the practice manager, nurses, the nurse manager, and reception and administrative staff. We also spoke with members of the patient participation group and patients who attended the practice that day and we observed how staff assisted patients when they arrived at the practice. We had asked patients to leave comment cards and share their view regarding the practice and the service they received and these were also reviewed during our inspection.

Good

Are services safe?

Our findings

Safe track record and learning

We reviewed the system in place for reporting and recording significant events There was an open and transparent approach and we noted that these were investigated and actioned. Appropriate actions had been taken and people affected by significant events received an apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. We saw that significant events had been entered onto the system and provided a link to the original document and that this was also the case for complaints. However, we noted that there had been no actions or learning shared from some events and there had been no regular review of events to identify any emerging themes.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. In the main lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw that MHRA alerts were sent to the prescribing lead and pharmacist who took appropriate action to notify the rest of the team.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. NICE guidance was circulated by the relevant clinical lead to other GPs in the practice and sometimes discussed at practice meetings. The practice told us they were planning to implement a monthly update at the meetings from each clinical lead.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and a second person allocated in the event of the other GPs absence. They had a robust system for identifying patients at risk which incorporated the use of a 'task tool', allowing staff to record actions at the time of their meeting. We saw evidence of effective information sharing within the multi-disciplinary team using the system allowing professionals to provide appropriate care based on up to date information. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- Notices were displayed in the practice advising to patients that a chaperone was available if required. The practice told us that only nurses acted as chaperones and we saw evidence to confirm this. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- We observed the premises to be visibly clean and tidy. There was an infection control protocol in place and appropriate standards of cleanliness and hygiene were being followed. The nurses were able to demonstrate awareness of infection control procedures and whilst some staff had received training there was some still outstanding. However, the nurse manager told us they were in the process of updating the training records and was prioritising areas where update training was outstanding. One of the practice nurses was the

infection control clinical lead and we saw a recent audit had been completed earlier in the month, but there had been no dates included to demonstrate when the actions identified during the audit would be completed.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of their own independent prescribing advisor to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescriptions were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and we looked at a selection of staff files which showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. (Disclosure and Barring checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

There was a system in place to alert all staff to an emergency within the practice. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had an automated external defibrillator (AED) available on the premises and oxygen with adult and children's masks. However, there were no AED pads available for children from 1 to 8 years. Following our inspection the practice informed us that they had purchased these and provided evidence to confirm this. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The practice told us this had been recently used as the result of a significant event when power had failed at the practice. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. They had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. GPs told us they sometimes discussed new guidance at practice meetings if relevant, but they were planning to arrange for the lead in each clinical area to provide monthly updates. The practice monitored that these guidelines were followed through risk assessments and audits.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a system intended to improve the quality of general practice and reward good practice. They used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results showed the practice had achieved 98.9% of the total number of clinical points available, with 22% exception reporting. Exception reporting prevents practices from being penalised when patients, for example, do not attend for review or where a patient cannot be prescribed a medication due to contra-indication or side effects. This practice was not an outlier for any QOF (or other national) clinical targets. They had a higher than the CCG and national average achievement in all QOF clinical areas except chronic obstructive pulmonary disease (COPD) and peripheral arterial disease. The practice had a specific GP who led and monitored the QOF process and identified any areas which required additional work. Data from 2014/15 showed;

- Performance for diabetes related indicators was higher than both the CCG and national average where they had achieved 97.7% compared to the 92.4% and 89.2% for the CCG and national averages respectively.
- The percentage of patients with hypertension having regular blood pressure tests was 85% which was similar to the CCG and national averages of 84.8% and 83.6% respectively.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We looked at three clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored. The practice also participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, recent action taken as a result included amendment of templates for annual review of patients with specific conditions.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and a comprehensive range of daily practice activities and a method of signing off staff as competent. The practice manager showed us the induction documentation for one of the most recent members of staff which confirmed this. We noted that infection control training had yet to be completed.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. The practice had introduced e-learning to provide easier access to appropriate training and to meet these learning needs and to cover the scope of their work. They also offered ongoing support, appraisals, clinical supervision and facilitation and support for the revalidation of doctors as well as protected learning sessions. All staff we spoke with had had an appraisal within the last 12 months except one who confirmed this had been arranged.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. We noted that some training was outstanding for some staff such as infection control equity and diversity and manual handling, but both the nurse manager and manager informed us that they were working to bring all of this up to date.They had introduced an online training package to help facilitate this process and staff also attended the local practice learning sessions.

Good

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

We noted there were good systems in place via the practice computer system for accessing and sharing information between professionals which allowed them to plan and deliver care and treatment promptly. We saw examples of where shared information had facilitated co-ordinated care specifically regarding safeguarding and end of life. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw that when children were at risk of harm or subject to child protection plans and moved from the area, the practice ensured their records were sent immediately to their new GP and they followed this up with a telephone call to ensure the information had been received. We saw evidence that multi-disciplinary team meetings took place on a monthly basis with Macmillan nurses and Age Concern and that care plans were routinely reviewed and updated. The practice also met with the district nurses weekly to discuss patients receiving palliative care.

The practice engaged in regular prescribing meetings with other practices in the locality to discuss benchmarking and best prescribing practices.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff could demonstrate an understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA). One of the GPs had recently undertaken MCA training and had disseminated this to the other GPs in the practice. Discussions with the nurse manager demonstrated that MCA training was one of the areas where they had identified gaps during their training needs assessment for nurses and was addressing this.

When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The practice did not carry out minor surgery procedures at this location but for other procedures requiring consent, such as immunisation, the practice met its responsibilities within legislation and followed relevant national guidance and consent was recorded on the clinical system.

Health promotion and prevention

The practice had a specific GP allocated to carry out health reviews on patients with learning difficulties in care homes and they told us they were about to commence weekly ward rounds at all care homes as part of a local enhanced service. Patients with dementia were reviewed using a computerised template to generate a care plan.

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, children and adults at risk of harm, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The practice offered smoking cessation in house and weight management support along with signposting to the local slimming club for additional support.

Patients were signposted to other relevant services and the practice employed the service of two counsellors to provide advice and support to patients suffering with mental health problems. They also hosted the wellbeing team at the practice to offer support these patients.

The practice had a comprehensive screening programme and uptake for the cervical screening programme was 92.5%, which was comparable to the CCG average of 81.9% and the national average of 81.8%. The practice followed up patients who did not attend for their cervical screening test in line with national guidance. They encouraged patients to attend national screening programmes for bowel and breast cancer screening and also hosted the abdominal aortic aneurysm (AAA) screening. Aortic aneurysm is a dangerous swelling in the aorta which is the main blood vessel from the heart down through the rest of the body.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For

Good

Are services effective?

(for example, treatment is effective)

example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94.5% to 98.5% and five year olds from 94% to 98.1%. Flu vaccination were offered and encouraged as well as the shingles vaccine for the those patients who met the criteria for immunisation.

Patients had access to appropriate health assessments and checks and the practice had recently commenced 40-74 year NHS health checks. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. The reception area was small and space was limited to allow patients to stand back and not be overheard. There was no line of demarcation to request patients to do this as far as possible. However, once checked in, patients were directed to a separate waiting area which did reduce the level of exposure. We did not see information advertising a facility to speak with a member of staff in private. Staff told us if patients did ask they would need to identify a consulting room that was available at the time.

The majority of the 23 patient CQC comment cards we received were positive about the care they received but two referred to the lack of privacy at reception.

Most patients reported they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. We also spoke with members of the patient participation group (PPG) on the day of our inspection. A PPG is a group of patients who work with the practice to represent the views of the practice population and help implement changes as a result. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some comment cards highlighted that staff could at times be rude. However, we noted on the practice action plan from the patient survey that customer service training was being arranged for reception staff. The majority of patients who responded commented that they were treated with compassion when they needed help and staff provided support when required.

Results from the national GP patient survey published in July 2015 showed patients responded positively to questions about how they were treated and that this was with compassion, dignity and respect. However, the practice was below the CCG and national average for its satisfaction scores on consultations with doctors and nurses. For example:

- 80.6% said the GP was good at listening to them compared to the CCG average of 87.4% and national average of 88.6%.
- 71% said the GP gave them enough time compared to the CCG average of 84.8% and national average of 86.6%.
- 91.5% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.4% and national average of 95.2%
- 72% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83.4% and national average of 85.1%.
- 85.7% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90.4%.
- 67.6% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84.9% and national average of 86.8%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment but results were below the local and national averages. For example:

- 76% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84.1% and national average of 86%.
- 67.4% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79.4% and national average of 81.4%.

The practice were aware of the scores which were lower than average and had developed an action plan to address

these issues. For example, they were continuing with a recruitment drive to increase capacity and allow clinicians more time to deal with patients and improve their experience. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

We saw a number of notices in the patient waiting room informing patients how to access a number of support groups and organisations and the practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and these patients were being supported, for example, by offering health checks and referral for support from the carers organisation. Information was available at reception, on the website and in the practice leaflet about carers, to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, this was recorded and added to relative notes. Their usual GP would either be contacted them by phone or written to, to provide advice regarding support services available and referral to specialist support if necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, they have engaged with the CCG and participated in the local enhanced service offered to provide weekly ward rounds at local care homes.

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

- The practice offered extended hours appointments in the evenings and Saturdays for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients and those patients who would benefit from these or could not attend the practice.
- Urgent access appointments were available for all patients who needed to see a GP without delay and a triage service had been introduced.
- There were disabled facilities, hearing loop and translation services available.
- There was a wheelchair available in the practice for patients with mobility problems.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with appointments available from 8.20am until 11.20am in the morning and 2.30pm and 5.30pm in the afternoon.Extended hours appointments were on Tuesdays and Thursdays from 6.30 until 8pm and Saturdays 8am until 10.30. In addition to pre-bookable appointments up to 21 days in advance, there were on the day appointments, telephone consultations, and telephone triage.

Results from the national GP patient survey published in July 2015 showed that patients' satisfaction with how they could access care and treatment was below the local and national averages and some of the comment cards reported difficulty in getting appointments. However, people we spoke with on the day told us although sometimes it could be difficult to get an appointment in advance, if they needed to see a GP urgently they were able to get an appointment. The national survey results reported:

- 54.6% of patients were satisfied with the practice's opening hours compared to the CCG average of 74.9% and national average of 74.9%.
- 24.8% patients said they could get through easily to the surgery by phone compared to the CCG average of 71.4% and national average of 73.3%.
- 44.3% patients described their experience of making an appointment as good compared to the CCG average of 71.9% and national average of 73.3%.
- 59.5% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66.6% and national average of 64.8%.

The practice had developed an action plan to address concerns regarding access to appointments and had committed to additional recruitment of GPs since January 2015 and had also employed three nurse practitioners. The practice had a local telephone number for the Desborough practice but had changed the 0844 number at their other practice in Rothwell in response to patient feedback, as patients used both surgeries to access services. Whilst they wanted to change the telephone system at Desborough to improve telephone access they were unable to do this due to contractual commitments until 2017. They were continuing to review appointment demand and the different types of appointments available, such as on the day, triage and appointments with nurse practitioners. They told us this was under constant review and were working with the PPG to carry out a new survey.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice and a GP lead for dealing with any clinical issues regarding complaints.

We saw that information was available in the waiting area to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at 24 complaints which had been received in the last 12 months and found they had been satisfactorily handled and dealt with in a timely way. We saw the practice had been open and transparent when dealing with the compliant and that they had learned from them. We saw a specific example regarding repeat prescribing where actions had been taken and learning shared with staff involved. The practice logged complaints on the system and details of them could be seen.

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 vision to deliver high quality care and promote good outcomes for patients. They met weekly as partners to discuss both business and clinical issues which involved future planning. For example, they were expecting an increase in demand due to new housing developments in the area over the next two to three years. The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had a governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured there was a clear staffing structure and that staff were aware of their own roles and responsibilities. We saw a spread sheet showing the lead GPs for all areas of work within the practice. For example, prescribing, learning disabilities, business, finance, safeguarding and significant events. There was also a detailed account of each manager's responsibilities.

We saw practice specific policies were implemented and were available to all staff such as infection control, whistleblowing, health and safety, pre-employment and induction. Clinical and internal audit had been used to monitor quality and to make improvements and the practice was committed to continuing this and sharing learning from it.

There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, for example, there had been a legionella risk assessment and fire risk assessment and actions were being implemented as a result.

Leadership, openness and transparency

The partners in the practice demonstrated a commitment to prioritising the delivery of safe, high quality and compassionate care. Staff told us they were visible in the practice and approachable and took time to listen to all members of staff. Practice nurses told us they felt supported and valued and that they could go to any of the GPs or the senior nurse for help and advice at any time. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held and that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt supported if they did. Staff said they felt respected, valued and supported, by the partners and manager in the practice. The practice had appointed a nurse manager to work more closely with the nursing team and we saw that they had started to implement training and systems to support the team. Staff were encouraged to develop, for example one nurse had requested to undertake additional training in family planning which was supported by the GPs.

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

The practice encouraged and valued feedback from patients regarding delivery of the service, specifically through the patient participation group (PPG) who were enthusiastic and active regarding improving services. A PPG is a group of patients who work with the practice to represent the views of the practice population and help implement changes as a result. They had carried out their own survey in addition to the national patient survey and were developing a new survey to take place in January 2016. They told us the practice listened to their views and supported their suggestions for improvement. For example, they had introduced a quarterly newsletter to improve communication in the practice and inform patients about what was available. This had started in spring 2015 and had been received well. It included information regarding the nurse practitioner's role electronic prescribing, and gave an account of the PPG member's experience who volunteered to spend an afternoon at reception to better understand their role and its challenges. The PPG told us that privacy at reception was an issue for them and that they intended to include this in the survey to determine the severity of it and work with the practice for a way to address it.

The practice had also gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management, for example, the practice manager gave an example of where the whistleblowing policy had been implemented successfully. Staff told us they felt involved and engaged in the practice.