

# Enys Road Surgery

## Quality Report

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East Sussex  
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Date of inspection visit: 18 December 2017  
Date of publication: 09/02/2018

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?

Requires improvement 

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

### Summary of this inspection

Overall summary

Page

2

### Detailed findings from this inspection

Our inspection team

4

Background to Enys Road Surgery

4

Detailed findings

5

Action we have told the provider to take

19

## Overall summary

### Letter from the Chief Inspector of General Practice

Enys Road Surgery was previously inspected in August 2015 and was rated good in all domains and overall.

**At this inspection in December 2017 the practice is rated as Good overall.**

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Enys Road Surgery on 18 December 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The practice operated a 'traffic light' system for patients who were high risk and needed a prompt response if they requested help.
- The practice offered an afternoon walk-in service for registered patients with urgent concerns.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice encouraged patient feedback and responded positively to patient needs.

# Summary of findings

- There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice taught external practitioners from several clinical disciplines and encouraged learning and improvement within their own staff.

The areas where the provider **must** make improvements as they are in breach of regulations are:

Establish effective systems and processes to ensure that care and treatment is provided in a safe way for service users. By:-

- Ensuring that the fire risk assessment is updated and all actions taken recorded.
- Ensuring all outstanding electrical work is completed.

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

- Review how GP registration is recorded and monitored on an ongoing basis.
- Consider having a GP check prescriptions issued, but not picked up by patients before destroying them.
- To adhere to the recruitment policy on all occasions.
- Review the low uptake of pneumococcal booster vaccine for children aged two.

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

# Enys Road Surgery

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser.

## Background to Enys Road Surgery

Enys Road Surgery provides primary medical services for approximately 8,400 registered patients.

Care and treatment is delivered by five GP partners. Four of the GP partners are female and one is male. The practice employs a team of two practice nurses, a nurse practitioner and two healthcare assistants. The practice were employing two paramedic practitioners who had start dates for early 2018. GPs and nurses are supported by the practice manager, two office managers, a finance manager and a team of reception and administration staff. The practice runs three clinics a week at the local university and many of the students are registered with them. The university employs a nurse who supports the GPs. The practice paid the university a small proportion towards the cost of the practice nurse service.

Services are provided from:

5-7 Enys Road, Eastbourne, BN21 2DQ

The practice runs a number of services for its patients including asthma clinics, diabetes clinics, new patient checks, minor surgical procedures, contraceptive services and travel vaccinations and advice.

There is an osteoporosis (a condition leading to weakened bones) service on-site that uses rooms supplied by the practice to house a scanner and administration staff. Although the service is owned by the partners, it is not part of the practice and was therefore not inspected.

The practice also hosts a carers' support service.

The practice is a training practice for qualified doctors in training to become GPs.

The practice delivers services to a higher percentage of patients who are aged 65 years and over than the national average, but lower than the local clinical commissioning group (CCG) average and a lower percentage of patients aged under 18 years when compared with the CCG and England average. Care is provided to over 400 patients living in residential and nursing home facilities. The practice also provides services to students within the local university and has a high proportion of 20 to 24 year old patients. Data available to the Care Quality Commission (CQC) shows the number of registered patients suffering income deprivation is just below the national average and above the clinical commissioning group (CCG) average.

At the time of the inspection, the registered manager had just de-registered and the practice were in the process of deciding on a replacement.

# Are services safe?

## Our findings

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

### Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks ensuring that all clinical staff had professional indemnity. All clinical staff were appropriately and currently registered and this was checked on recruitment. However the practice did not monitor this on an ongoing basis and once staff were employed, they left it to the individual clinician to do so. We noted a single incidence where a member of staff was employed without following the practices recruitment policy in respect to advertising the post. We were told this was because they knew that the candidate had the skill set they were looking for. Other than advertising the role the practice had followed all other elements of the policy including obtaining references from past employers. Interview notes had not been retained in recruitment records although we were told that they had only recently been removed as it was not deemed necessary to keep them any longer. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

### Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

### Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

### Safe and appropriate use of medicines

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

## Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Prescriptions that were not picked up by patients were destroyed by shredding after a suitable period of time, however they were not always checked by a GP first.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

### Track record on safety

The practice had a good safety record.

- There were risk assessments in relation to safety issues. These included a variety of risk assessments in place to monitor safety of the premises. This included general health and safety, control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The building was walked round and checked weekly and a three monthly health and safety risk assessment recorded.
- We saw that fire extinguishers had been serviced, alarms and lighting were tested regularly and regular fire drills were carried out. There were fire wardens allocated to each floor and floor plans contained in the business continuity plan. A fire risk assessment had been completed in September 2014 and reviewed in March 2016. However, the assessment did not clearly show if all actions had been completed.

- An electrical safety risk assessment had been carried out in January 2016 but actions required had not been completed. The practice was aware of this delay and had organised a further assessment to ensure that nothing had changed during the delay in having remedial works carried out.
- The practice monitored and reviewed activity. They had employed an outside agency which they used for up to date health and safety advice and monitoring. This helped it to understand risks. However not all issues in respect to electrics had been resolved, a formal fire risk assessment review was due and a record of actions completed following the previous review was not available.

### Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following an emergency event at the practice, the response was fully examined as a significant event at a clinical meeting. In response changes were made to room layouts, and the location of emergency equipment.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as good for providing effective services overall and across all population groups.**

### Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group age sex prescribing unit showed low prescribing of antibiotics.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

### Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Housebound patients were identified and offered visits if appropriate including flu vaccinations. The practice had patients at 64 care homes and visited when required.
- Two paramedic practitioners had been appointed and were due to start in January 2018 to assist with the high volume of home visits that the practice undertook.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Patients who cannot manage the stairs or stair lift are offered a consultation in a downstairs room.

### People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Multi-disciplinary team (MDT) meetings were held monthly.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice had a Proactive Care practitioner who visited patients in their own homes if they had been identified as a non-attender, or a very frequent attender.
- The practice held twice weekly referral meetings at which challenging or unusual situations were discussed.

### Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the target percentage of 90% or above. Of the four indicators examined one was 100%, one 90%, one 87% and one 63% (children aged two who had received a pneumococcal booster).
- The practice had appointments at the surgery and at the university specifically for gynaecological problems.

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

- The practice's uptake for cervical screening was 88%, which was higher than the CCG average of 82% and 81% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. New students were encouraged to arrange to have the vaccine at events during freshers' week.
- The GPs held three clinics a week at the local university campus during term time.
- The practice contributed to the cost of a nurse who was employed by the university.



# Are services effective?

## (for example, treatment is effective)

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- The practice was part of the vulnerable patient scheme and was increasing the number of clinicians who were carrying out home visits to the vulnerable and house bound.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice held monthly palliative care meetings.
- Vulnerable patients were discussed at multi-disciplinary team (MDT) meetings.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. Homeless people could register at the practice using the practice address.
- Patients with learning disabilities are offered a review at their own place of residence. The practice used the opportunity to assess unmet health needs.

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

- 79% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the clinical commissioning group (CCG) average (82%) and national average of 84%
- 91% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the CCG average (91%) and national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 86%; CCG 90%; national 91%);

and the percentage of patients experiencing poor physical and/or mental health who had received discussion and advice about smoking cessation (practice 95%; CCG 93%; national 95%).

### Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. For example, a two cycle audit was carried out to discover if all male patients on a medicine that suppressed male sex hormones had had a scan to assess bone density (low bone density is a potential side effect of these medicines). A second audit showed that as a response to the initial audit all male patients taking these medicines had now been scanned for low bone density.

The most recent published Quality Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 96%. The overall exception reporting rate was 16% compared with a local average of 13% and national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) This is above CCG and National averages. The practice explained that they would send patients three reminder letters, each a month apart, to attend a review. If they did not respond the case would be passed to the relevant GP to assess whether the patient should be exception reported. The practice were hoping to improve the number of attendees by sending reminders by text message after an initial letter to patients that had a mobile phone.

Exception reporting in some chronic disease domains was higher than local or national averages. For example, Chronic Obstructive Pulmonary (lung) Disease 29%, (CCG 15%, national 13%) and Hypertension 15% (CCG 6%, national 7%). The practice told us that they have a very high proportion of patients in nursing and care homes (they see patients in 64 homes) and that there are therefore many more patients that fall in to exception categories.

The practice also had a higher than average exception reporting of cervical screening rates of 26% (CCG 8%,



# Are services effective?

## (for example, treatment is effective)

national 7%). In mitigation of this the practice have pointed out that they have a very high transient population, with a large immigrant population, mature students at the university doing post graduate degrees and a transient worker population as they have many seasonal workers. However the practice also dispute the high exception reporting figures, but as these figures record data over a five year period, no longer have the records to evidence this.

- The practice used information about care and treatment to make improvements. For example the practice had previously had a lower than expected number of women attending for cervical screening. They changed their policy and now phone patients to remind them and also opportunistically reminded them when they brought their children to be immunised. They now have cervical screening rates above local and national averages (recorded as a positive variation by CQC data analysts).
- The practice was actively involved in quality improvement activity. For example, the practice had done the preparatory work and were applying for a more advanced accreditation in infection control.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, they took part in regular locality meetings with representatives from the CCG and other local practices. They were also about to embark on a national research project.

### Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff discussed

difficult and unusual cases at twice weekly meetings. The induction process for healthcare assistants included the requirements of the Care Certificate. Healthcare assistants were closely monitored by senior nursing staff and worked within their training and capabilities.

- There was a clear approach for supporting and managing staff when their performance was poor or variable.

### Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The practice operated a 'traffic light' system for patients who were high risk and needed a prompt response if they requested help. If a patient was red or amber, their names and rating were posted on a board in the office so that if they called in staff knew that they should be put through to speak to a clinician urgently.
- The practice held monthly multi-disciplinary team (MDT) meetings with representatives from the district nursing, adult social care, mental health and palliative care teams as well as Proactive Care practitioners. Any decisions made about patients were recorded directly in to their digital notes.

### Helping patients to live healthier lives

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

# Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice had bid and received money to promote healthier lifestyles. In partnership with the patient participation group (PPG), they had purchased screens for the waiting room to promote healthy living and had almost completed a newsletter specifically about healthy living.

- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

## **Consent to care and treatment**

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 25 patient Care Quality Commission comment cards we received were positive about the service experienced although two of these were mixed. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 284 surveys were sent out and 110 were returned. This represented about 1.3% of the practice population. The practice was average for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 85% of patients who responded said the GP gave them enough time; CCG - 89%; national average - 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 97%; national average - 95%.
- 90% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 89%; national average - 86%.
- 91% of patients who responded said the nurse was good at listening to them; (CCG) - 95%; national average - 91%.

- 94% of patients who responded said the nurse gave them enough time; CCG - 95%; national average - 92%.
- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 99%; national average - 97%.
- 93% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 95%; national average - 91%.
- 90% of patients who responded said they found the receptionists at the practice helpful; CCG - 91%; national average - 87%.

### Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. One of the staff was multi-lingual and able to support some of the Chinese community.
- Staff communicated with patients in a way that they could understand, for example large print notices were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

The practice proactively identified patients who were carers through the new patient application form, website and notice board. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 81 patients as carers (1% of the practice list). The practice hosted a local carer's service and signposted patients to it.

Staff told us that if families had experienced bereavement, their usual GP contacted sent them a sympathy card. This call would have been followed by a patient consultation and/or by giving them advice on how to find a support service if appropriate.

## Are services caring?

Results from the national GP patient survey showed patients generally responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were mostly in line with local and national averages:

- 80% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 82% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average - 82%.

- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 93%; national average - 90%.
- 93% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 89%; national average - 85%.

### Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

### Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, online services such as repeat prescription requests and advanced booking of appointments.
- They offered a walk-in service for patients with urgent concerns in the afternoon and saw any registered patient that attended.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the building had a stair lift installed and a downstairs consultation room was available to patients who could not use the stairs or stair lift.
- There was an accessible toilet and baby changing facilities.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

#### Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme. Each nursing and care home had a named GP.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice had employed two paramedic practitioners who would also be involved in home visits.

#### People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with a wide variety of health and social care professionals to discuss and manage the needs of patients with complex medical issues.

#### Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice supplied sexually transmitted disease self-test kits. They offered contraceptive services including being part of a scheme for issuing condoms to young people.

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

- The surgery had a walk in 'emergency/urgent care' clinic each afternoon, which was run by the doctor on duty and assisted at times by the registrar, nurse practitioner or paramedic. This started at 3.00pm and finished when the last person was seen.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice offered online services such as appointment booking and repeat prescriptions as well as text reminders of appointments.

#### People whose circumstances make them vulnerable:

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. Homeless people could be registered at the practice, using the practice as their home address.
- Patients with a learning disability could be seen for an annual review in their own place of residence or have an extended appointment at the practice.
- The practice was increasing the number of clinicians who could undertake home visits to the vulnerable and housebound.

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

- Patients with dementia were offered reviews in their own residence. The practice used the opportunity to assess unmet health needs.
- The practice provided rooms for local carer and mental health services.
- The practice worked with the local crisis team, adult social care and locality link worker.
- Patients with mental health concerns were treated as a priority with regards to appointments if they were feeling particularly unwell or vulnerable.

### Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use. Appointments could be booked by phone, online or face to face. Reminders were sent by text, the text system was also used as a way of recording feedback.
- The practice offered a variety of appointments – routine pre-bookable, same day, emergency, telephone

appointments and home visits. They also offered a walk-in clinic in the afternoon where any registered patient with an urgent problem could wait and would be seen.

- Messages could be left for the doctor, nurse, or manager to call the patient back.
- The nurse practitioner triaged urgent appointments in the morning.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 284 surveys were sent out and 110 were returned. This represented about 1% of the practice population.

- 75% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 79% of patients who responded said they could get through easily to the practice by phone; CCG – 70%; national average – 71%.
- 80% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG – 87%; national average – 84%.
- 76% of patients who responded said their last appointment was convenient; CCG – 86%; national average – 81%.
- 77% of patients who responded described their experience of making an appointment as good; CCG – 77%; national average – 73%.
- 71% of patients who responded said they don't normally have to wait too long to be seen; CCG – 61%; national average – 58%.

### Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.

## Are services responsive to people's needs? (for example, to feedback?)

- The complaint policy and procedures were in line with recognised guidance. Seven complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. They held complaints/significant events meetings during which trends were looked for to improve the quality of care.



# Are services well-led?

Good 

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

## Our findings

**We rated the practice as good for providing a well-led service.**

### Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills.

### Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

### Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. For instance, we saw that staff members who became pregnant had a risk assessment carried out and acted upon.
- The practice promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

### Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. Administrative staff were put in to task specific teams of two or three. This was to ensure

# Are services well-led?

Good 

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

there was always someone available who could deal with all major areas of work. Each team had a leader and were given responsibility for an area of practice administration.

- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- Partners held regular minuted meetings which the practice manager and often a member of the patient participation group (PPG) attended.

## Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was generally an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. However, an electrical safety risk assessment had been carried out in January 2016 but actions required had not been completed. .
- The practice had processes to manage current and future performance. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice held monthly clinical meetings which were attended by all clinicians including the nurse from the university. In addition to this they had twice weekly meetings where difficult or unusual cases could be discussed.
- The practice had plans in place and had trained staff for major incidents. We saw an example of where a serious clinical event had occurred onsite and had been dealt with adequately with a positive outcome.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

## Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings.
- The practice used performance information which was reported and monitored. They had an open, no blame attitude to learning from this information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

## Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For instance the practice had received money to promote healthier lifestyles. In partnership with the PPG, they had purchased screens for the waiting room to promote healthy living and had almost completed a newsletter specifically about healthy living. Staff were also due to go on a course on promoting healthier lifestyles.
- There was an active PPG which met monthly and supported the practice. Their opinion was canvassed and considered on a variety of issues. They also produced a practice newsletter every four months. Patients were encouraged to join the PPG, minutes and agendas for meetings were posted on a notice board and on the website. PPG members attended some local stakeholder meetings. A representative of the PPG sometimes attended the partners' meetings.

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Good 

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- The service was transparent, collaborative and open with stakeholders about performance.

## Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the practice. The practice had a strong ethos of training and learning. They hosted young people on work experience and provided training for nurses, paramedics, pharmacists, medical students, post graduate doctors and doctors who were specialising in general practice. They had also taken on an apprentice administrator who was offered a permanent post after their training.
- Staff knew about improvement methods and had the skills to use them. One of the GPs was qualified to train doctors who wished to become GPs.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had just enrolled to carry out research.
- They had recently appointed two paramedic practitioners who were due to start in the New Year to mainly carry out urgent care consultations and home visits.
- The practice encouraged staff to take on further training to increase their skill set. For example, one of the practice nurses had undergone further training and was now a nurse practitioner and two receptionists (trained as phlebotomists), one was now trained as a health care assistant and the other was an acting office manager. They had also taken on an apprentice who was now working for the practice as a permanent staff member.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The service provider had failed to ensure that care and treatment was provided in a safe way for service users. The service provider had not :-</p> <ul style="list-style-type: none"><li>• Ensured all actions taken from the March 2016 fire risk assessment had been recorded and that a new fire risk assessment had been completed.</li><li>• Ensured action required had been completed from the January 2016 electrical safety risk assessment.</li></ul> <p>This was in breach of Regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>