Dr Gigurawa Wijethilleke

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?	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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Gigurawa Wijethilleke's practice on 29 September 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice although the practice did not review outcomes of the actions taken.
- Risks to patients were generally assessed and well managed although there was no legionella risk assessment for the building (legionella is a term for a particular bacterium which can contaminate water systems in buildings). Also, the practice had never carried out any fire drills.
- The practice had arrangements in place to respond to emergencies and major incidents, however, the practice did not have a defibrillator.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Staff who acted as chaperones were trained for the role although one of these staff had not received a DBS check or been risk assessed for the role. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with the GP and there was continuity of care, with urgent appointments available the same day.
- 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 proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider must make improvement are:

- Complete a risk assessment for legionella at the surgery.
- Identify and assess the risks associated with the absence of a defibrillator in the surgery building.

The areas where the provider should make improvement are:

- The practice should consider putting systems in place to check that actions identified by significant event reports are effective.
- Allow for recruitment arrangements to include all necessary employment checks for all staff. For example, Disclosure and Barring Service (DBS) checks or risk assessments for all staff including those providing a chaperone service for patients.
- Consider undertaking regular fire drills to test full evacuation of the building in the event of a fire.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice although the practice did not review outcomes of the actions taken.
- Although risks to patients who used services were generally assessed, there was no legionella risk assessment for the building (legionella is a term for a particular bacterium which can contaminate water systems in buildings). Also, the practice had not carried out any fire drills to test evacuation from the building.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. Staff who acted as chaperones were trained for the role although one member of staff had not received a DBS check or been risk assessed. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) The practice told us that they would address this immediately.
- The practice did not have a defibrillator and had not carried out a risk assessment for not having one in the building, despite identifying a risk following a significant event at the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment. The principal GP and practice nurse had specialist knowledge of the care of patients with diabetes. Diabetic patients were reviewed at the practice first by the nurse and then the GP in consecutive appointments. The GP had a background in surgery which supported his minor surgery procedures at the practice.
- There was evidence of appraisals and personal development plans for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice contacted all patients over 75 years of age who had had an unplanned admission to hospital to see whether their needs were met and if a care plan was needed. An appointment with the GP was arranged if appropriate within one week of discharge.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. Some results indicated lower satisfaction scores for consultations with the GP and the practice had looked at this with their own survey.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We were told that staff always listened to patients and that nothing was too much trouble.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group to secure improvements to services where these were identified. They were working with other practices in the area to improve patient access to GP services on Thursday afternoons.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good 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 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.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 was an overarching governance framework which generally supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk although the practice had failed to risk assess the lack of a defibrillator in the practice. There had been a related significant event and there was documented discussion of that event and actions taken.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active although small. The practice was looking to extend this group.
- There was a strong focus on continuous learning and improvement at all levels.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice contacted all patients over 75 years of age who had had an unplanned admission to hospital to see whether their needs were met and if a care plan was needed. An appointment with the GP was offered within a week of discharge if appropriate.
- A podiatrist visited the practice each month to provide a clinic for patients.
- The practice encouraged the uptake of the national bowel screening service and there were posters displayed in the waiting room. The practice put an alert on patient records if they failed to attend screening and staff encouraged those patients when they attended the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- The practice nurse was trained in the management of patient chronic disease and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was better than the local and national average. For example, the percentage of patients who had their blood sugar levels well-controlled was 90% compared to the local average of 80% and national average of 78% and the percentage of patients with blood pressure readings within recommended levels was 92% compared to the local average of 80% and national average of 78%.
- The principal GP and practice nurse had specialist knowledge of the care of patients with diabetes. They offered a weekly clinic at the surgery for diabetic patients.
- The practice provided a blood monitoring service for patients who were taking anti-coagulation medications and a phlebotomist visited the practice every week to take blood samples.

Summary of findings

- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients 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 relatively 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.
- The practice's uptake for the cervical screening programme was 81% which was a little lower than the CCG average of 85% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice kept a register of members of families in the same household who had different surnames to aid communication.
- The practice nurse was also a midwife at the local hospital which informed her practice at the surgery.
- We saw positive examples of joint working with midwives, health visitors and school nurses and the practice held a weekly baby clinic.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

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

Summary of findings

- Patients could telephone or text the practice for requesting repeat medication as well as submitting requests online or in person.
- The practice offered extended hours GP appointments on three evenings a week until 7pm and a pre-bookable surgery on most Saturday mornings for those patients who found it difficult to access the practice during working hours.
- Telephone appointments were available as well as face-to-face..

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 those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. The practice held monthly meetings to discuss the care of these patients.
- The practice informed 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).

- 89% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84%.
- 92% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.

Summary of findings

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing generally in line with local and national averages. There were 234 survey forms distributed and 103 were returned (44%). This represented 3.8% of the practice's patient list.

- 97% of patients found it easy to get through to this practice by phone compared to the local average of 71% and national average of 73%.
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 88% and national average of 85%.
- 86% of patients described the overall experience of this GP practice as good compared to the local average of 89% and national average of 85%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 81% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards which were all positive about the standard of care received. Patients said that staff were kind and professional and always willing to help. One card also said that they felt that there were occasions where they had not been understood but many mentioned the fact that they felt that the doctor always listened to them.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. One patient also spoke of communication problems which they had resolved after discussion with staff.

Areas for improvement

Action the service MUST take to improve

- Complete a risk assessment for legionella at the surgery.
- Identify and assess the risks associated with the absence of a defibrillator in the surgery building.

Action the service SHOULD take to improve

- The practice should consider putting systems in place to check that actions identified by significant event reports are effective.
- Allow for recruitment arrangements to include all necessary employment checks for all staff. For example, Disclosure and Barring Service (DBS) checks or risk assessments for all staff including those providing a chaperone service for patients.
- Consider undertaking regular fire drills to test full evacuation of the building in the event of a fire.

Dr Gigurawa Wijethilleke

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to Dr Gigurawa Wijethilleke

Dr Gigurawa Wijethilleke, also known as Medicare Unit Surgery, is based in a two storey house situated in the centre of the Lostock Hall area of Preston at 1 Croston Road, Lostock Hall, Preston, PR5 5RS. Patient facilities are mainly situated on the ground floor. These comprise of a reception area, waiting room, reception office, consulting room, treatment room and accessible toilet. There is a further treatment room on the first floor which is used occasionally for minor surgery.

The practice provides level access for patients to the building. It has a small car park for patients and staff and there is also a public car park across the road. The practice has public transport nearby.

The practice is part of the Chorley with South Ribble Clinical Commissioning Group (CCG) and services are provided under a General Medical Services (GMS) contract.

There is one principal male GP and one practice nurse, a practice manager who also acts as a medicines co-ordinator and three administrative and reception staff who support the practice.

The practice is open from 8am to 6.30pm every day from Monday to Friday and extended hours are offered on Mondays, Tuesdays and Wednesdays from 6.30pm to 7pm and on most Saturdays from 9am to 12noon. Appointments are available from 8.20am to 12noon and from 3.20pm to 6.10pm every weekday with extended hours appointments on Mondays, Tuesdays and Wednesdays from 6.30pm to 7pm. There is no bookable afternoon surgery on a Thursday when appointments finish at 12noon. Saturday morning appointments run from 9am to 11.30am.

The practice provides services to 2,716 patients. There are higher numbers of patients aged over 40 years of age (56%) than the national average (46%) with more patients aged between 60 and 75 years of age than the national average (19% compared to 15%).

Information published by Public Health England rates the level of deprivation within the practice population group as eight on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Both male and female life expectancy is comparable to the local and national average, 82 years for females compared to 83 years nationally and 79 years for males compared to 79 years nationally.

The practice has a slightly higher proportion of patients experiencing a long-standing health condition than average practices (57% compared to the national average of 54%). The proportion of patients who are in paid work or full time education is lower (58%) than the CCG and national average of 62% and unemployment figures are higher, 10% compared to the CCG average of 3% and national average of 5%.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 September 2016. During our visit we:

- Spoke with a range of staff including the principal GP, the practice nurse and four members of the practice administration team.
- Spoke with three patients who used the service including one member of the practice patient participation group (PPG).
- Observed how staff interacted with patients and talked with family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Staff involved in the significant event met to discuss the incident and agreed actions that needed to be taken. Staff not involved in the incidents were informed of significant events at practice meetings. However, the practice did not review outcomes of the actions taken.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, when a patient had been missed for a recall to the practice for a cytology test, the practice apologised to the patient and put systems in place to ensure that it would not happen again. However, we saw details of one significant incident when a patient collapsed in the practice. One of the outcomes of this incident was documented to say that the practice would purchase a defibrillator. This action had not been completed and the practice had agreed informally to use a defibrillator that was available in the public car park nearby. They had not known about the location of this equipment before the significant event. We saw minutes of a meeting where the use of this defibrillator was discussed and staff went to view the equipment. Staff told us that they were aware of the location of the defibrillator and how to access it; however, the practice had not carried out a formal risk assessment to identify and quantify the risks of not having a defibrillator available in the building and to ensure the defibrillator in the car park was regularly serviced and maintained.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. 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 and there was a contact list on the reception office wall. The GP was the lead member of staff for safeguarding. The principal GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GP was trained to child protection or child safeguarding level 3 and the practice nurse to safeguarding level 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and the practice nurse usually acted as the practice chaperone. A tabard was available for non-clinical staff to use when chaperoning patients. One staff member had not received a Disclosure and Barring Service (DBS) check or been risk assessed for the role since joining the practice although they had only acted as a chaperone twice. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) The practice told us that they would ensure that this was addressed.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and

staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice manager acted as the practice medicines co-ordinator for this and attended monthly meetings for the role. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed three personnel files and found 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 (DBS). There was no DBS check for one newer member of staff although the practice had accepted one done by the previous employer. The practice told us that they would address this.

Monitoring risks to patients

Risks to patients were generally assessed and well managed.

- 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 which identified local health and safety representatives. The practice had up to date fire risk assessments although they had not carried out regular fire drills. 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 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. The practice did not have a legionella risk assessment in place (legionella is a term for a particular bacterium which can contaminate water systems in buildings). They told us that they would arrange for this following our visit.
- 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 enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had oxygen with adult and children's masks available on the premises. A first aid kit and accident book were also available. However, the practice did not have a defibrillator. Following a significant event, the practice had agreed to use a defibrillator available at the nearby public car park area although they had not completed a risk assessment for 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 stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with 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 keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments and audits.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.5% of the total number of points available. Exception reporting figures for the practice were lower than the clinical commissioning group (CCG) and national averages (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice exception reporting figure overall was 6.7% compared to the CCG average of 9.9% and the national average of 9.2%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was better than the CCG and national average. For example, the percentage of patients who had their blood sugar levels well-controlled was 90% compared to the local average of 80% and national average of 78% and the percentage of patients with blood pressure readings within recommended levels was 92% compared to the local average of 80% and national average of 78%.
- Performance for mental health related indicators was similar to or higher than the local and national average. For example, 92% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the local average of 93% and national average of 88% and 89% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the local average of 88% and national average of 84%.

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits completed in the last year. In addition, there were several patient medication audits and audit of patient outcomes. Some of these were audits that were repeated regularly such as the audit of patients admitted to hospital who were aged over 75 years old.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, when an audit showed that some patients taking a particular drug for pain had not been given clear dosage instructions or a follow up date for review, the practice addressed this and reviewed those patients appropriately.

Information about patients' outcomes was used to make improvements. For example, the practice audited patients aged over 75 years of age who had been admitted to hospital following an attendance at the hospital accident and emergency service or through the out of hours service. The practice discussed those patients admitted through the out of hours service with the service to clarify when admission was judged to be appropriate.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Administrative staff had trained in conflict resolution and clinical staff in patient end of life care.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

Good

Are services effective?

(for example, treatment is effective)

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings and local forums.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for the GP revalidation. All staff had received an appraisal within the last 12 months except one staff member who was relatively new to the practice and had had regular informal assessments of progress. We saw that a formal appraisal was planned.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, in-house training and external training usually arranged by the CCG.
- The practice nurse was also a midwife at the local hospital which informed her practice at the surgery. The GP had a professional background in surgery which supported his minor surgery procedures at the practice.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice contacted all vulnerable people who were discharged from hospital and arranged an appointment with the GP within a week of discharge if appropriate. They also automatically contacted all patients over 75 years of age who had been admitted to hospital as an unplanned event to see whether their needs were met and if a care plan was needed. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. The practice sent out a list of patients for consideration before each meeting and we saw comprehensive minutes of these meetings where patients were discussed and care plans updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and patients experiencing memory loss. Patients were signposted to the relevant service.
- A podiatrist was available on the premises each month and smoking cessation advice was available from a local support group. A midwife also visited the practice every other week.

The practice's uptake for the cervical screening programme was 81% which was comparable to the CCG average of 85% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test and they ensured a female sample taker was available. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend

Good

Are services effective?

(for example, treatment is effective)

national screening programmes for bowel and breast cancer screening and there were posters displayed in the waiting room. The practice put an alert on patient records if they failed to attend screening and the staff encouraged those patients when they attended the practice.

Childhood immunisation rates for the vaccinations given were higher than CCG and national averages. For example, childhood immunisation rates for the vaccinations given to one year olds were all 100% compared to the CCG average of 97% to 98% and national average of 73% to 93%, and for five year olds from 90% to 100% compared to the CCG average of 92% to 99% and national average of 81% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs or take them to the reception office door where it was quieter.

All of the 21 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was lower than average for its satisfaction scores on consultations with GPs and higher than average for its satisfaction scores on consultations with nurses. For example:

- 84% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 91% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 97% and the national average of 97%.
- 97% of patients said the nurse was good at listening to them compared to the CCG average of 92% and the national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

One of our patient comment cards said that they felt that there were occasions when they had not been understood but many mentioned the fact that they felt that the doctor always listened to them. One patient who we spoke to mentioned communication problems but said that they had resolved this after discussion with staff.

Care planning and involvement in decisions about care and treatment

Patients told us 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were again variable when compared with local and national averages. For example:

- 77% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%.

Good

Are services caring?

- 95% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 90%.
- 94% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

The practice had conducted its own patient survey in 2015 with a small number of patients who were involved in the patient participation group and had published the following results:

- 100% of patients said that they felt the GP was "Very Good" at giving them enough time.
- 75% of patients said that they thought the GP was "Very Good" about asking them about their symptoms and the remaining 25% qualified this as "Good".
- 50% of patients said that they thought the GP was "Very Good" about listening and the remaining 50% qualified this as "Good".
- 75% of patients said that they thought the GP was "Very Good" at involving them in decisions about their care and the remaining 25% qualified this as "Good".
- 100% of patients said that they thought that the GP was "Very Good" at giving them enough time.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in the practice waiting area and one patient told us that the information provided was useful and relevant.
- The practice was small and staff knew the patients which aided communication. For example, staff communicated in writing with patients with a hearing difficulty.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 29 patients as carers (1.1% of the practice list). The practice was aware that this was a low number and told us that they planned to improve identification of carers by including information in the new patient information pack and by inviting members of the local carers' support organisation into the practice to speak to staff. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them when it was appropriate This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. The practice was in discussion with neighbouring practices and the CCG to provide services collaboratively from a central hub. The first aim of the project was to offer patient GP surgeries on a Thursday afternoon.

- The practice offered a 'Commuter's Clinic' on a Monday, Tuesday and Wednesday evening until 7pm and on Saturday morning from 9am to 12 noon for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and those with complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. We saw an example of a baby being seen by the GP as an emergency after surgery had finished.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities and translation services available.
- The practice occasionally used one treatment room on the first floor to offer minor surgery to patients. If patients were unable to use the stairs, the service was moved to a downstairs room.
- The practice telephoned vulnerable patients discharged from hospital and arranged an appointment with the GP if necessary. They also automatically contacted all patients over 75 years of age who had had an unplanned admission to hospital to see whether their needs were met and if a care plan was needed.
- The principal GP and practice nurse had specialist knowledge of the care of patients with diabetes. Diabetic patients were reviewed at the practice first by the nurse and then the GP in consecutive appointments. A clinic for diabetic patients was offered every week.
- The practice provided a clinic every week at the practice for patients who were taking anti-coagulant medication to prevent blood clotting. A phlebotomist also visited the practice weekly to take patient blood samples.
- The practice kept a register of members of families in the same household who had different surnames to aid communication.
- A midwife visited the practice every two weeks and the practice held a weekly baby clinic.

Access to the service

The practice was open from 8am to 6.30pm every day from Monday to Friday and extended hours were offered on Mondays, Tuesdays and Wednesdays from 6.30pm to 7pm and on most Saturdays from 9am to 12noon. Appointments were available from 8.20am to 12noon and from 3.20pm to 6.10pm every weekday with extended hours appointments on Mondays, Tuesdays and Wednesdays from 6.30pm to 7pm. At the time of inspection there was no bookable afternoon surgery on a Thursday when appointments finished at 12noon. Saturday morning appointments ran from 9am to 11.30am.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

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

- 91% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 76%.
- 97% of patients said they could get through easily to the practice by phone compared to the CCG average of 71% and national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Patient requests for home visits were listed on the practice clinical computer system and given to the GP to assess the urgency of need. Reasons for requests were recorded on the patient record. The GP usually contacted the patient

Good

Are services responsive to people's needs?

(for example, to feedback?)

first before visiting. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. We saw evidence of discussion at a practice meeting regarding home visits following a patient safety alert received by the practice.

Listening and learning from concerns and complaints

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

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

The practice had only received two complaints in the last year. We looked at these complaints and found they had been dealt with in a timely way and with openness and honesty. Lessons were learnt from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, the process for recalling patients for cytology screening was improved and the affected patient received an apology from the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a statement of purpose and core values and staff knew and understood the values. We were told that the first objective of the practice was "to provide an effective and high quality General Practice service, committed to the health needs of all our patients."
- The practice was working with other neighbouring practices to ensure that there was continuity of care for patients in the local area. They were looking to provide a full GP service to patients on Thursday afternoons by forming a GP federation. The practice had no formal succession plan although informal discussion had taken place as to the way forward.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained. There was a strong framework of meetings that were well documented. The practice manager met with the GP every week to discuss service issues.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were generally good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions although the practice lacked a legionella risk assessment (legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice had also failed to risk assess the lack of a defibrillator in the practice even though there had been a related significant event. There was documented discussion of that event and actions taken to address the risk of not having a defibrillator in the building.

Leadership and culture

On the day of inspection the principal GP demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the GP was approachable and took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings. Whole practice meetings were held every month.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the principal GP and practice manager. All staff were involved in discussions about how to run and develop the practice and the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff had identified a system to record patient requests for medications that were not on repeat which had been adopted by the practice.

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

Are services well-led?

Good

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG was a small, virtual group who carried out patient surveys and submitted proposals for improvements to the practice management team. For example, to improve patient confidentiality in reception, all chairs were moved away from the reception window. Also, patients were given better access to requesting repeat medication and the practice allowed patients to telephone or text the surgery as well as using the usual methods of requesting prescriptions. The practice was looking to extend the group and advertised it in the waiting area, to new patients and online on the practice website.
- The practice had gathered feedback from staff 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. Staff told us they felt involved and engaged to improve how the practice was run. The service for patients over 75 years of age who were contacted by the practice following discharge from hospital had been started following a suggestion by a member of staff.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. They were working with other practices in the area to improve patient access to GP services on Thursday afternoons. It was hoped that this federated service would be able to offer shared services such as a treatment room service and shared staff, facilities and policies and procedures. It was also hoped that the practices could work together in times of unplanned staff absence.

The practice had expressed an interest to the clinical commissioning group in providing an integrated diabetes service pilot scheme.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment** How the regulation was not being met: The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. The practice had not completed a risk assessment for legionella at the surgery. The practice had not identified and assessed the risks associated with the absence of a defibrillator for emergency use in the surgery building. This was in breach of regulation 12(1)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.