Ailsa Craig Medical Centre

Quality Report

Ailsa Craig Medical Practice
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ailsa Craig Medical Practice on 13th August 2015. Overall the practice is rated as good. Specifically the practice were found to be good for effective, caring, responsive and well led services. They required improvement in safety.

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

- Understanding about how to raise concerns, and to report incidents and near misses was inconsistent among the staff. Information about safety was recorded, monitored, reviewed and addressed, but this was done in an informal way between clinical staff, and meetings were not minuted.
- Most risks to patients were assessed and well managed.
- Risk and management of areas associated with infection control, waste disposal and equipment checks required improvement.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Data showed patient outcomes were at or above average for the locality.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice were very responsive to the diverse needs of their population in particular with regard to cultural or religious practices which could have adverse reactions on the person's health and wellbeing such as self management of diabetes.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- On Mondays and Fridays the practice opened at 7.30am and all the clinicians (including the nurse on a Friday) held surgeries where patients could be seen from 7.30am until 10.30am..
- The practice was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

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

Importantly the provider must

- Maximise opportunities for learning by ensuring that all members of staff, clinical and non-clinical understand what constitutes an event of significance to be recorded and reported. These should include verbal comments and complaints received from patients which are otherwise dealt with at the time. Sharing and learning of these events should be formalised and include all members of staff.
- Review systems to manage medicines and infection control checks and ensure they are effective. Liaise with the local infection control team to ensure they are meeting the required standards of cleanliness and infection control.

In addition the provider should

- Ensure that all staff receive an annual appraisal and that training needs are identified.

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. Not all staff had the same understanding about how to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed but this was done in an informal way between clinical staff and meetings were not minuted. Although risks to patients who used services were assessed, not all the systems and processes to address these risks were implemented well enough to ensure patients were kept safe. We found a number of clinical apparatus which were out of date and had not been appropriately disposed of.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health and staff worked with multidisciplinary teams. Staff received most training required to carry out their roles sufficiently. There was evidence that appraisals had taken place but it was not consistent for all staff and some reported as not having had an appraisal for over two years.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for some aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw that staff treated patients with kindness and respect, and maintained confidentiality, but the age of the building made it difficult to maintain privacy and some conversations could be overheard during consultations. However, staff were conscious of confidentiality and ensured personal information was not discussed in these areas.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Summary of findings

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had 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 that the practice responded quickly to issues raised. When complaints were made they were reviewed and learning was shared with appropriate members of staff when required.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. They had tried to engage a patient participation group (PPG) and were looking at ways to increase members and engage the group so that it was useful. Staff had received inductions and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. They had identified that more nursing time was required and were providing training to enable lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients with long term conditions had a named GP and reviews were offered to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were comparable for all standard childhood immunisations. Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school times and a dedicated, open access, baby clinic was available once a week.

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

Summary of findings

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 reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. They were aware of patients living in vulnerable circumstances including those with a learning disability, victims of domestic violence, frailty and/or safeguarding issues. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. One of the GPs had attended training on female genital mutilation to better understand this and support patients who may have suffered.

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 and they were aware of an ageing population with increased mental health needs. They took part in a directed enhanced service to facilitate timely diagnosis and support people with dementia. We noted 83% of patients diagnosed with dementia had received a face to face review in the preceding twelve months which was equal to the national average.

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

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. 462 surveys were sent out and 85 were completed. This was an 18% completion rate and represented approximately 1% of the practice population.

- 90% find it easy to get through to this surgery by phone compared with a CCG average of 74% and a national average of 73%.
- 87% find the receptionists at this surgery helpful compared with a CCG average of 86% and a national average of 87%.
- 56% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 55% and a national average of 60%.
- 78% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 83% and a national average of 85%.
- 100% say the last appointment they got was convenient compared with a CCG average of 88% and a national average of 92%.
- 77% describe their experience of making an appointment as good compared with a CCG average of 71% and a national average of 73%.
- 59% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 57% and a national average of 65%.
- 40% feel they don't normally have to wait too long to be seen compared with a CCG average of 51% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. No comment cards were completed. The GP lead for the day, told us that the patients at the practice preferred to offer their comments verbally and did not write down suggestions or comments that the practice could review.

Areas for improvement

Action the service MUST take to improve

- Maximise opportunities for learning by ensuring that all members of staff, clinical and non-clinical understand what constitutes an event of significance to be recorded and reported. These should include verbal comments and complaints received from patients which are otherwise dealt with at the time. Sharing and learning of these events should be formalised and include all members of staff.
- Review systems to manage medicines and infection control checks and ensure they are effective. Liaise with the local infection control team to ensure they are meeting the required standards of cleanliness and infection control.

Action the service SHOULD take to improve

Ensure that all staff receive an annual appraisal and that training needs are identified.

Ailsa Craig Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser, and an Expert by Experience. An Expert by Experience is someone who has used health and social care services.

Background to Ailsa Craig Medical Centre

Ailsa Craig Medical Practice is situated in Central Manchester and provides services to over 9,000 patients in Ardwick and Longsight under a Primary Medical Services contract. It is a deprived area. 70% of the practice population are BMI, with 36% Pakistani and 22% English or White British. More than a third of the patients are between the ages of 20 and 40 years. The practice have catered and adjusted the services they offer to meet the needs of their diverse population.

The building is a large semi-detached house, which has been converted into a Doctors' surgery. Inside, GP consulting rooms, nurse treatment rooms and staff offices are spread over four floors. There is no lift and the stairs to consulting rooms on the middle floors are steep, however the practice have adapted the premises so that older people with frailty conditions or people with disabilities can be seen on the ground floor.

There are three GP partners (1 male and 2 female) and one female salaried GP who is currently on maternity leave. A long term locum (a previous GP trainee by the practice) is covering that position. There is a full time, long standing, practice nurse and a newly appointed part time nurse.

There is also a part time health care assistant and extra cover provided when required, by a member of administration who has been trained in phlebotomy. They are a training practice, accredited by the Deanery and are currently training one GP registrar.

On Mondays and Fridays the practice opens at 7.30am and all the clinicians (including the nurse on a Friday) hold surgeries where patients can be seen from that time until 10.30am. On the other days it opens from 8am and closes at 6.30pm every day except Wednesday. On Wednesdays the practice is open in the afternoon for nurse appointments only, although patients can still attend the practice to collect prescriptions or discuss administration. If they telephone on a Wednesday afternoon, or any other time when the surgery is closed, they will be directed to the on-call services which are also available to them at the weekends. Patients registered at this practice can also be seen at a nearby GP co-operative from 6.30pm until 8.30pm.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13th August 2015. During our visit we spoke with a range of staff including the GP who was leading for the day, one of the partners, a locum GP and the GP trainee. We also spoke to the lead nurse and the health care assistant. In addition we spoke to the practice manager, reception and administration staff and patients who used the service. We observed how people were being cared for and talked with carers and/or family members. There were no comments cards to review where patients and members of the public had shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Different staff we spoke to offered different views on how events of significance should be reported, recorded and reviewed and how they were discussed. Some staff told us they would inform the practice manager or one of the GPs of any incidents and others said there was a recording form available on the practice's computer system but these were completed only by the GPs if required and not by all staff prior to discussions.

Complaints received by the practice were entered onto a system and recorded separately. Some of the complaints we looked at were significant events but it was not clear whether they were reported as such. We saw learning points and actions taken in response to complaints and people affected received a timely and sincere apology and were told about the actions taken to improve care.

We were told that significant events were discussed at weekly clinical meetings which took place. Those meetings were attended by the GPs and nurses but had been suspended recently due to annual leave. The meetings did not follow a formal agenda and did not include all members of staff. This meant that there was no formal record to show which events had been reported, whether they had been discussed and how decisions had been reached about the rating of significance. The practice should check that clinical and non-clinical members of staff understand events that need to be reported and follow a consistent process to record, monitor and review risk.

Information from a range of sources such as National Institute for Health and Care Excellence (NICE) guidance was also used to monitor safety.

Overview of safety systems and processes

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

- Arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs 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 relevant to their role.
- All clinical and administration staff have undertaken training in domestic violence and the practice have received IRIS accreditation. Domestic violence counselling is available in-house if required and the practice worked closely with the IRIS team, (Identification and Referral to Improve Safety).
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. All staff had a Smart Card which is something that is issued to an individual proving their identity to a national standard.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice had recognised where there were short falls and had adjusted their

recruitment processes accordingly. For example they were training a nurse who had not previously worked in general practice and had also provided an employment opportunity to an administration apprentice.

- Mostly the arrangements for managing medicines, including obtaining, prescribing, recording and handling medicines, kept patients safe. Regular medicine audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The emergency medicines we checked were in date and fit for use. Two similar looking ampoules containing different medicines were stored next to each other and were not easily differentiated. Consideration should be given to the risk of choosing the wrong drug in an emergency situation.
- Checks to ensure that medicines were stored and disposed of in line with requirements were the responsibility of administrative staff and were not sufficient. We found injections (vitamin B12) stored in a cupboard without a lock and injectable long acting contraceptive (Depo-Provera) kept in a locked cupboard alongside other materials such as computer screen cleaner.
- Prescription pads and electronic sheets were securely stored in lockable cupboards but a system was required to monitor and log the serial numbers of prescriptions ordered, received and used.
- We observed the premises to be clean and tidy. The lead practice nurse was the infection control clinical lead and all staff said they would report issues to that person. The lead nurse reported that this was a new role. There was an infection control protocol in place and staff said that all training was delivered in-house by the practice nurse. The practice completed a self-assessment audit and had identified that some action was required However they had not yet liaised with the local infection prevention teams to keep up to date with best practice or initiated a full infection control audit. Such an audit would identify whether appropriate standards were being met, particularly in relation to waste disposal and the correct usage of sharps bins which were not all of the correct type and were not appropriately dated and signed.
- The infection control policy identified lead roles and responsibilities. One such role was to check that sterile equipment and supplies were maintained and kept in date. The checks were ineffective. We found blood bottles, hypodermic needles, butterfly cannula, vacutainer lancets (used for venepuncture) and other sterile equipment including containers for histology samples which were all out of date. We were advised that minor surgery at the practice had been suspended six months previously but found suture material and other single use instruments (used mainly in minor surgery) with an expiry date of 2013.

Arrangements to deal with 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 a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.

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. Not all clinical staff we spoke to were aware of the plan or where it was kept.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment 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 ensure all clinical staff were kept up to date. The practice nurse was aware of guidance for her specific areas of work and was able to access updated resources via the practice nurse forum and the NICE website. Any information that needed to be shared was circulated via email or personal contact. The practice used guidelines from NICE to develop how care and treatment was delivered to meet needs.

They checked that guidelines were followed through risk assessments, audits and random sample checks of patient records. The practice also received medicines related alerts from the Medicines Management Team, along with NICE updates and Clinical Commissioning Group (CCG) updates were shared verbally at clinical meetings or by email.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework(QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

We reviewed the most recent QOF results (2013/14) for the practice which showed that 96.5% of the total number of points were received with 9.5% exception reporting. The practice was not an outlier for any QOF (or other national) clinical targets.

Data from our intelligent monitoring showed;

- Performance for diabetes related indicators were higher compared to the national average. The practice averages ranged between 68% and 92% against the national averages of 77% and 88%. The lead nurse had a specific interest in diabetes and monitored the uptake of the practice patients to ensure they received the treatments that were available to them.
- The percentage of patients with hypertension having regular blood pressure tests was 86% which was similar to the national average of 83%.
- Performance for mental health related indicators were similar to expected for the CCG and national average. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record was 88%. This was higher than the national average of 86%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 83% which was similar the national average of 83%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. Three Clinical Audits were submitted but only one was a complete audit cycle and related to pneumococcal vaccination in diabetics. The other two audits both concluded with a plan to re-audit in the coming year. The pneumococcal vaccine audit was of a high quality and following the initial audit, patients were contacted if their treatment could be improved. New systems were put in to place to improve uptake of this vaccination in the longer term. Re-audit was completed and demonstrated an improvement. The other two audits both led to system changes but had not yet been re-audited to check if improvements had been achieved.

All three audits were linked to diabetes and selection of audit topics was random. Planned audits for the coming year were chosen following input from the medicines management team and the Clinical Commissioning Group and were more varied.

The lead nurse was also involved and had also audited patients with poorly controlled diabetes and people who received new diabetic medication. The nurse tried to prioritise her audits and was currently on the second phase of an asthma review which was looking at the relevant use of inhalers.

Effective staffing

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

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs although some staff had not received an appraisal for more than two years.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions (for trainees), clinical supervision when requested and facilitation and support for the revalidation of doctors.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of some e-learning training modules and in-house training.

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 test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans which were in place for some patients, were reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to other relevant services where they could gain further support. The practice nurse and health care assistant offered advice on the premises around smoking cessation and good diet. A high proportion of the practice patients chewed pan masala (a type of chewing tobacco) which can be a contributor to mouth cancer. The practice had increased awareness to their patients of the risks involved and offered advice on reduction and control.

The practice had a comprehensive screening programme and the uptake for the cervical screening programme at 88% was higher than the national average of 81%. The practice were also working on ways to improve patient attendance at cervical screening, breast screening appointments (which was low at only 30% attendance) and bowel screening.

Administration staff were responsible for the call and recall of patients who required or did not attend screening appointments and they printed information for the practice nurse to make contact. They also had access to a system which checked information about failed call and recall.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 97% and five year olds from 82% to 95%. Flu vaccination rates for the over 65s were 66% and at risk groups 63%. These were also comparable to CCG and national averages which were 73% and 52% respectively.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations but conversations taking place in reception could be clearly heard in one of the treatment rooms. This was a known concern and low level music in the consulting room was being considered as an option. The 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 the patients we talked to said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients told us they knew that conversations could sometimes be overheard and none of them said they had any concerns about this. They said that staff responded compassionately when they needed help and provided support when it was required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was below average for some of its satisfaction scores on consultations with doctors and but above average for the results about the nurses. For example:

- 85% said the GP was good at listening to them compared to the CCG average of 85% and national average of 89%.
- 84% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%.
- 88% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82% and national average of 85%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 90%.
- 87% patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.
- 98% had confidence and trust in the last nurse they saw or spoke to compare to the CCG average of 95% and national average of 97%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. One patient was extremely grateful for the care they had received which had resulted in several lifesaving interventions.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results about the GPs and nursing staff were in line, or higher than local and national averages. For example:

- 81% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 94% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 86% and national average of 90%.
- 84% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%
- 85% say the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 80%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and several of the GPs and administration staff were able to speak several languages, specifically those used by a high number of the practice population.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer and the staff were very knowledgeable about the patients in their population and their demographics. The practice used dementia templates which contained a section about carers. There was no specific register but carers could be identified by alerts on the electronic records. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or 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 worked with the local CCG to plan services and to improve outcomes for patients in the area. They were aware of an ageing population with increased physical and mental disability and a population with extensive diabetes. Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care.

- The practice provided surgeries from 7.30am until 10.30am on Monday and Friday mornings for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disabilities and language difficulties.
- The practice had been accredited for the service they provided to patients with heart failure, by setting up registers, reviewing patients and case finding.
- Extensive diabetic specialist training had been carried out by the nurse and patients can now receive new medicines such as Gliptins and GLPS without having to refer to specialist services.
- Home visits were available for older patients and the practice offered an access service to Oakland House which is a nursing home for mental health patients.
- The premises had been adapted to take into account the frailty of some of its patients.
- Urgent access appointments were available for children and those with serious medical conditions.
- The GPs and reception staff spoke several languages pertinent to the patients at the practice.

Access to the service

The practice opened on Mondays and Fridays at 7.30am and all the clinicians (including the nurse on a Friday) held surgeries where patients could be seen from that time until 10.30am. Tuesdays, Wednesdays and Thursdays they were open 8am and closed at 6.30pm. On Wednesdays afternoons the practice was open in the afternoon for nurse appointments only, although patients could still attend the practice to collect prescriptions or discuss administration. If they telephoned at any time when the surgery was closed, they were directed to the on-call services which were also available to them at the weekends. Patients registered at this practice could also be seen at a nearby GP co-operative from 6.30pm until 8.30pm daily. Appointments were bookable over the telephone, at the surgery and on-line. Routine appointments could be booked up to two weeks in advance and urgent on the day appointments were available every day, if required, following a telephone consultation with a GP.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 91% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 90% patients said they could get through easily to the surgery by phone compared to the CCG average of 74% and national average of 73%.
- 100% patients described their experience of making an appointment as good compared to the CCG average of 88% and national average of 92%.

Listening and learning from concerns and complaints

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

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

We looked at five complaints received in the last 12 months and found that they were satisfactorily handled, dealt with in a timely way and that the practice had been open and transparent when providing a response. GPs reflected on their practice and discussed with each other whether they could do anything to improve the quality of the care provided.

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 mission statement which was displayed in the waiting areas and staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. It outlined structured procedures and ensured that most staff understood and were aware of their own roles and responsibilities. We found that

:

- Opportunities for sharing information and learning when things went wrong could be expanded to include all members of staff equally.
- Practice specific policies were implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality and make improvements and more widespread and random audits were being introduced to cover more areas.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, a few of which required improvement.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held although some of these had recently been suspended due to staff absence. We saw there was an open culture within the practice and staff had the opportunity to raise any issues. They said they felt confident in doing so and supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

The practice had been accredited by the Deanery for their work in the training and development of specialist trainee first, second and third year doctors.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service where they could. They had tried to gather feedback from patients through the patient participation group (PPG) and through surveys and complaints received, however they found that their patients preferred to verbalise their comments rather than writing them down. Not all verbal comments and complaints were formally reported, recorded and treated in the same way as written ones and this minimised the opportunity for shared learning and analysis of trends.

Innovation

The practice identified iatrogenic problems caused in 10 per cent of their population and recently stopped all pharmacists from re-ordering prescriptions on behalf of their patients. Iatrogenic problems are problems that can be caused by long-term medicines that no longer need to be taken. Some patients were receiving repeat medicines which were being automatically sent out by the pharmacies. The practice identified a cost saving of £65,000 which was applauded by the Clinical Commissioning Group.

The practice had recognised that cultural and religious beliefs could have a detrimental effect on patient's health. They had prepared and provided information specifically for Muslim patients with diabetes who may be fasting during the period of Ramadan. The information provided awareness about when it would not be safe for patients to fast and what to do if they encountered difficulties during the fast. This information was shared with the CCG and then with other practices within the area.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The systems in place to assess, monitor and improve the quality and safety of services provided were not consistent.** **The systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk were not consistent.** **The systems in place to seek and on feedback from relevant persons and other persons on the services provided were inconsistent.** Regulation 17 (1), (2)(a)(b) and (e)