Shakespeare Health Centre

Quality Report

Elers Road Clinic
Elers Road
Hayes
UB3 1NY
Tel: 020 3794 3119
Website: www.shakespearehealthcentre.nhs.uk

Date of inspection visit: 14 July 2016
Date of publication: 19/12/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Shakespeare Health Centre on 14 July 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.
- The provider was aware of and complied with the requirements of the duty of candour.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Most patients said they found it easy to make an appointment 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 the partners, the lead GP and management. The practice proactively sought feedback from staff and patients, which it acted on.
- The current practice partners had successfully turned around the performance of the practice, for example as measured by the Quality and outcomes framework. The practice was willing to experiment and trial new ideas for the benefit of patients.

We saw one area of outstanding practice:

- The partners were in the process of implementing a clear strategy to improve the management of long

Summary of findings

term conditions. The effective use of clinical audit, accredited training for the whole team and the employment of a pharmacist had transformed the management and control of diabetes within a year.

The areas where the provider should make improvement are:

- The practice should improve levels of patient uptake for cervical, bowel and breast cancer screening to reduce the risk of patients developing avoidable cancers or the late detection of cancers.
- The practice should improve its identification of patients who are also carers and ensure their needs are assessed.
- The practice should do more to protect vaccines and any other medicines required to be kept cold in line with current guidelines.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- 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.
- 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.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Data from the Quality and Outcomes Framework (QOF) showed the practice tended to be at or above average for most indicators.
- The practice population had a high prevalence of diabetes. The practice scored above average for its performance on managing diabetes.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients consistently rated the practice higher than others for the quality of consultations with GPs and nurses.
- We saw staff treated patients with kindness and respect, and took care to protect patients' confidentiality.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were fully involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible at the practice.

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 NHS England, the clinical commissioning group and was active in the local GP federation to secure improvements to services where these were identified.
- Most patients said they could make an appointment when they needed one. Urgent appointments were 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 vision and strategy to deliver high quality care and promote good outcomes for patients. The practice could show significant improvements to the care provided for patients with long term conditions as a result.
- There was a clear leadership structure and staff felt supported by the partners and manager. The practice had policies and procedures to govern activity.
- There was an overarching governance framework which supported the delivery of good quality care. This included arrangements to monitor and improve quality and identify risk.
- The partners, the lead GP and practice managers encouraged an open culture. The practice complied with the duty of candour.
- The practice sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels. The practice was keen to explore new ideas and innovations where these were likely to benefit patients.

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 provided the seasonal flu vaccination for patients over 65 and the shingles and pneumococcal vaccinations for eligible older patients. The practice ensured that housebound patients received these vaccinations.
- The practice had access to a named local care coordinator who could visit older patients at home and could signpost patients to other services, clubs and events, for example, to reduce social isolation.
- One of the practice's clinical objectives was to reduce the ill-effects of polypharmacy (that is, where patients take multiple medicines).The practice employed a pharmacist who carried out medication reviews and liaised with local pharmacies to ensure prescription changes were actioned safely.
- However, some patients told us that the geographical relocation of the practice disproportionately affected older patients who were less likely to drive.

People with long term conditions

Good

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

- The practice kept registers of patients with long term conditions. These patients had a structured annual review to check their health and medicines needs were being met. The practice operated a call-recall system to encourage patients to attend for their review and attached a reminder to patients' prescriptions.
- The prevalence of diabetes was high locally at 12%. The practice had recently provided their administrative staff with diabetes awareness training to ensure the whole practice team understood the importance of diagnosis and regular monitoring.

Summary of findings

- Practice performance for diabetes was above average. The percentage of diabetic patients whose blood sugar levels were adequately controlled was 83% compared to the clinical commissioning group average of 75%.
- The practice participated in a local scheme to avoid unplanned admissions which included patients with multiple long term conditions. Patients identified as at risk were reviewed and had a personalised care plan. Cases were discussed at regular multidisciplinary meetings.

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 higher than average for all standard childhood immunisations.
- Children and young people were treated in an age-appropriate way and were recognised as individuals. The premises were suitable for children and babies
- Appointments were available outside of school hours.
- We saw positive examples of timely communication and referral to health visitors and other community health services.

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 and flexible.
- The practice was open from 8:30am until 6.30pm during the week with an additional early morning session from 7am-8am every Tuesday following patient feedback. GP nurse and phlebotomy appointments were available in the early morning session.
- The practice offered a range of ways to access services, for example, daily telephone consultations with a GP, online appointment booking and an electronic prescription service.

Summary of findings

- The practice offered a full range of health promotion and screening services reflecting the needs for this age group. The practice had identified a number of patients with previously undiagnosed diabetes through its programme of NHS health checks.
- 71% of eligible women registered with the practice had a recorded cervical smear result in the last five years compared to the CCG average of 80%.

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 people with a learning disability.
- The practice offered longer and same day appointments for patients with a learning disability.
- The practice maintained a register of patients who were also carers. Carers were offered regular reviews and flu vaccination.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- 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).

- 71% of patients with dementia had attended a face to face review of their care in the last year compared to the CCG average of 81%.
- The practice engaged patients with dementia in discussions around advanced directives and involved carers in these discussions where appropriate. Interpreters were arranged for patients who spoke English as a second language before carrying out any memory assessment.
- The practice regularly liaised with specialist teams in the case management of patients experiencing poor mental health.
- The practice was able to advise patients experiencing poor mental health and their carers how to access various support groups and voluntary organisations.

Summary of findings

- 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.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice's results were variable when compared to the local and national averages. The survey programme distributed 362 questionnaires by post and 100 were returned. This represented 3% of the patient list (and a response rate of 28%).

- 40% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 69% and the national average of 73%.
- 69% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 81% and the national average of 85%.
- 96% had confidence and trust in the last GP they saw or spoke to compared to the CCG average of 92% and the national average of 95%.
- 65% of patients described the overall experience of this GP practice as good compared to the CCG average of 79% and the national average of 85%.

We spoke with three patients during the inspection and received 25 completed patient comment cards. Patients were very positive about care they received at the practice, for example consistently describing the clinical staff as caring and going out of their way to help. Several patients gave us examples of personalised and compassionate care they had received, and being fully involved, for example, in setting up a care plan.

Patients told us on the day of the inspection that they were able to get appointments when they needed them and telephone access did not seem to be a major concern. The patient participation group representative we spoke with said that practice had recently made significant improvements to telephone access.

The practice had relocated to alternative premises around four miles away from its original location. Some patients told us they found the journey to the new location longer or more difficult and this affected their experience of the service overall. We were told that older patients in particular had left the practice and transferred to other practices closer to their homes.

The practice had an active patient participation group and members told us the practice was responsive to suggestions and had made improvements as a result of patient feedback. For example, the practice now opened between 7am-8am every Tuesday for the benefit of working and school age patients.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The practice should improve levels of patient uptake for cervical, bowel and breast cancer screening to reduce the risk of patients developing avoidable cancers or the late detection of cancers.
- The practice should improve its identification of patients who are also carers and ensure their needs are assessed.
- The practice should do more to protect vaccines and any other medicines required to be kept cold in line with current guidelines.

Outstanding practice

- The partners were in the process of implementing a clear strategy to improve the management of long term conditions. The effective use of clinical audit, accredited training for the whole team and the employment of a pharmacist had transformed the management and control of diabetes within a year.

Shakespeare Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Shakespeare Health Centre

Shakespeare Health Centre provides NHS primary medical services to around 4000 patients in Hayes, in the Hillingdon Clinical Commissioning Group area. The service is provided through a general medical services contract.

The current practice clinical team comprises two GP partners and two salaried GPs. The practice employs three part time practice nurses (one whole time equivalent), a clinical pharmacist who was an independent prescriber, and a phlebotomist. The practice also employs a practice manager and administrative and reception staff. The GPs typically provide around 21 sessions in total each week. Patients have the choice of seeing a male or female GP.

The practice is open from 8.30am until 6.30pm during the week with an additional early morning session between 7am-8am every Tuesday. Same day appointments are available for patients with complex or more urgent needs. The practice offers online appointment booking. The GPs make home visits to see patients who are housebound or are too ill to visit the practice.

When the practice is closed, patients are advised to use a contracted out-of-hours primary care service if they need urgent primary medical care. The practice provides information about its opening times and how to access urgent and out-of-hours services in the practice leaflet, on its website and on a recorded telephone message.

The practice population profile differs from the national average in having a higher proportion of families with children under five. The population in the local area is characterised by average levels of income deprivation, life expectancy and unemployment. The practice population is ethnically diverse.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder and injury.

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 14 July 2016. During our visit we:

Detailed findings

- Spoke with a range of staff including the GP partners, a practice nurse, the practice manager, the clinical pharmacist, a health care assistant and a receptionist.
- Observed how patients were greeted on arrival at the practice.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 25 comment cards where patients and members of the public shared their views and experiences of the service.
- Interviewed three patients and met one member of the patient participation group.
- Reviewed documentary evidence, for example practice policies and written protocols and guidelines, audits and monitoring checks.

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.

Good

Are services safe?

Our findings

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.
- The practice carried out a thorough analysis of significant events and an annual review.

We reviewed safety records, incident reports and patient safety alerts. The practice kept a log of significant events, critical incidents, near misses and relevant alerts. Significant events were discussed at both clinical and staff meetings and minutes retained.

We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following a medical emergency, the practice had reorganised its emergency trolley and relocated it for greater accessibility. The practice had also amended its emergency protocol, recommending that staff calling an ambulance should do this, whenever possible, in the presence of the leading clinician so accurate information can be passed to the emergency services.

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 to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements.
- Safeguarding 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. The practice had designated leads for safeguarding children and vulnerable adults. The GPs provided safeguarding related reports where necessary for other statutory agencies. Staff demonstrated they understood their responsibilities and all staff (including the administrative staff), had received training on safeguarding children and vulnerable adults relevant to their role. The GPs and practice nurses were trained to child safeguarding level 3.
- Notices in the waiting and consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. One of the GP partners was the lead for infection control in the practice and the practice nurses were responsible for monitoring infection control practice day to day. The practice had comprehensive infection control policies in place including hand washing, handling of specimens and handling of 'sharps'. Staff had received up to date training on infection control. The practice carried out annual infection control audits. The most recent audit had not identified any actions for improvement.
- The practice had effective arrangements for managing medicines safely (including obtaining, prescribing, recording, handling, storing, security and disposal of medicine). Processes were in place for handling repeat prescriptions which included the review of high risk medicines and regular review of patients on long-term prescriptions. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The practice had systems in place to ensure vaccines and any other medicines were stored at the appropriate temperature but these did not fully meet current guidelines. For example, the practice should regularly

calibrate the thermometer used to check the temperature of the vaccines fridge, and, clearly label the fridge plug to ensure the fridge is not inadvertently switched off.

- Patient group directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- We reviewed 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had appropriate health and safety policies and protocols in place with named leads. The practice did not own the premises but could provide a copy of the fire risk assessment which was up to date. The practice carried out regular fire drills.
- All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. The property management agency had risk assessments in place to monitor safety such as control of substances hazardous to health; infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Again the practice was able to provide copies.
- Arrangements were in place for planning and monitoring the number of staff needed to meet patients' needs. There was a rota system in place to ensure enough staff were on duty with the appropriate skill mix.

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.
- There were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and child masks. A first aid kit and accident book were available. The practice had recently experienced a medical emergency and the GPs and staff had responded promptly and in line with their emergency protocol. The practice had reviewed this event and had made improvements to the siting and organisation of the emergency trolley as a result.
- 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 local 'pathways' agreed by the clinical commissioning group (CCG) and used this information to deliver care and treatment that met patients' needs. The practice was an active member of its locality group of practices and was keen to use this as a vehicle for local health improvement projects.
- The practice monitored that guidelines were followed through group discussion, audits, medicines reviews with individual patients and checks of patient records. The practice was able to show us several examples of audits against CCG prescribing guidelines, for example an audit of statin prescribing had identified a number of patients who needed their medicines reviewing and a change of prescription.
- Clinicians used standardised templates within the electronic patient record system for care planning and reviews of long term conditions. These incorporated good practice guidelines, for example, prompts for discussions around advance decisions, preferred place of care and preferred place of death for patients receiving palliative care.

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 for 2015/16 were 98.4% of the total number of points available compared to the national average of 95.4%. The practice exception reporting rates were in line with the average. (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).

Data from 2015/16 showed:

- The prevalence of diabetes was high locally. The practice prevalence rate for diabetes was 12%. Practice performance for diabetes related indicators was above the local and national averages. For example, 83% of diabetic patients had blood sugar levels that were adequately controlled (that is, their most recent IFCC-HbA1c was 64 mmol/mol or less) compared to the CCG average of 75% and the national average of 78%. Eighty-seven per cent of practice diabetic patients had a recent blood pressure reading in the normal range compared to the CCG and national average of 78%. The practice's exception reporting rates for diabetes indicators were close to the national average.
- The practice provided a wide range of information for patients about diabetes. All newly diagnosed patients were referred to a structured education course about the condition and how to manage it.
- The practice had also targeted educational interventions and advice on patients with raised risk factors for diabetes, for example through the NHS health checks programme.
- In 2015/16, 71% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, compared to the CCG average of 81% and the national average of 83%.
- For patients with a diagnosis of psychosis, 91% had an agreed, comprehensive care plan which was in line with the CCG and national averages.

There was evidence of quality improvement including clinical audit.

- Clinical audits were prompted by changes and updates to guidelines, significant events and safety alerts.
- The practice used clinical audit as a tool to monitor and improve its performance. The practice had logged almost 30 audits over the previous year, several of which were completed two-cycle audits where changes had been implemented and then reaudited to ensure the improvement had been sustained. Topics included the prescribing of broad spectrum antibiotics, the prevalence of tuberculosis in the practice population and reducing the number of missed appointments.
- The practice participated in locality based audits, national benchmarking and peer review and regularly liaised with the local NHS prescribing team. Findings were used by the practice to improve services. For

Good

Are services effective?

(for example, treatment is effective)

example the audit of broad spectrum antibiotic prescribing showed that the practice had become one of the lower prescribing practices in the CCG. The practice had reviewed its prescribing protocols which were discussed with the clinicians.

Effective staffing

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

- The practice had a structured 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, the administrative staff had received awareness training about common long term conditions because the practice recognised that these staff had a role to play in encouraging patients to engage with services.
- 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 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.
- 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 on going support, one-to-one meetings, team meetings and informal discussion and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months or had an appraisal booked.
- We were told that reflection, learning and development was encouraged. For example, the practice held clinical and team meetings. Clinical meetings included discussion of guidelines or a clinical topic. The practice sometimes invited an external speaker, for example, a clinical specialist in respiratory medicine had attended a meeting in 2016 to discuss COPD (chronic obstructive pulmonary disease) and asthma.
- All staff received mandatory training that included: safeguarding, fire safety awareness, basic life support and information governance.

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 treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

The practice participated in the local integrated care programme aiming to avoid unnecessary hospital admissions for patients assessed to be at high risk. One of the practice partners was the locality lead for integrated care. Practice clinicians attended monthly multidisciplinary meetings in the locality at which care plans were routinely reviewed and updated for patients with complex needs. The practice also held monthly in-house multidisciplinary meetings and routinely liaised with health visitors, district nurses and the local palliative care team to coordinate care and share information.

The practice maintained a 'Coordinate my care' register for patients with complex needs or on palliative care. This ensured that other services such as the ambulance and out of hours services were updated with key information in the event of an emergency or other unplanned contact.

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.

Good

Are services effective?

(for example, treatment is effective)

- 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 nurse assessed the patient's capacity and, recorded the outcome of the assessment. The practice had systems in place to ensure that where patients had made advance decisions, these were communicated to other services when necessary, for example, to the ambulance service if attending out of hours.

Supporting patients to live healthier lives

The practice identified patients 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.

- In 2015/16, 71% of eligible women registered with the practice had a recorded cervical smear result in the last five years compared to the CCG average of 80%. The practice had reviewed this performance and discussed the importance of following up women who had not attended for their cervical screening test at a practice meeting. The practice ensured a female sample taker was available. There were failsafe 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 national screening programmes for bowel and breast cancer screening. In 2014/15, the uptake for breast cancer screening was 57% which was below the CCG average of 69%. Bowel cancer screening uptake was 39% compared to the CCG average of 51%.
- Childhood immunisation rates were high. For example in 2015/16, 90% of eligible babies had received the 'five in one' vaccination by the age of two years. For the preschool cohort, 78% had received their booster vaccinations. The practice followed up children who did not attend their initial appointments.
- 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. The staff carrying out health checks were clear about risk factors requiring further follow-up by a GP. The practice had identified a number of patients with undiagnosed diabetes as a result of carrying out routine checks.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were polite and helpful to patients and treated them with respect.

- Curtains 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 were able to take patients to a more private area if they needed to discuss sensitive issues or appeared distressed.
- The practice had a Tamil-speaking doctor and we were told this was valued by patients originating from Sri Lanka.

Patients who participated in the inspection were very positive about care they received at the practice, for example consistently describing the clinical staff as caring and going out of their way to help.

Results from the national GP patient survey reflected these findings. The practice tended to score in line with the national and local averages for patient experience of consultations, particularly with a GP. For example:

- 88% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78% and the national average of 85%.
- 67% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.
- 70% of patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

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. Patients gave us examples of being fully involved, for example, in setting up a care plan. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision. We 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. The practice results tended to be in line with the local averages particularly for consultations involving a GP. For example:

- 79% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% 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 75% and the national average of 82%.
- 73% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 85%.

The practice partners were optimistic that patient satisfaction was improving and participated in the Friends and family survey. The most recent results from this survey were that 83% of patients would recommend the practice.

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 17 patients who were carers (0.4% of the practice list). The practice offered carers the flu vaccination and priority for appointments. Written information was available to direct carers to the various avenues of support available to them.

Good

Are services caring?

Staff told us that if patients had suffered bereavement, the GP would visit or telephone and the practice sent a condolence card. The practice signposted patients to bereavement support services and recorded the bereavement in their medical records to ensure the clinical team would be aware.

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, the clinical commissioning group (CCG) and was active in its locality group of GP practices to secure improvements to services where these were identified.

- The practice offered blood tests and spirometry testing at the practice and also in-house 24 hours blood pressure monitoring to patients.
- There were longer appointments available for patients with a learning disability or other more complex needs.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and patients with urgent medical problems.
- The practice offered travel vaccinations. The practice provided information about which vaccinations were available free on the NHS and which were available privately for a set fee.
- There were disabled facilities and translation services. The practice was located on the ground floor of a health centre and all areas were accessible to people with disabilities.
- Patients were able to request appointments with a male or female GP.

Access to the service

The practice was open from 8.30am until 6.30pm during the week with an additional early morning session between 7am-8am every Tuesday. Same day appointments were available for patients with complex or more urgent needs. During the winter months, the practice ran flu vaccination clinics on Saturday mornings.

The GPs made home visits to see patients who were housebound or too ill to visit the practice. Same day appointments were available for patients with complex or more urgent needs. The practice offered online appointment booking.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment tended to be below the local and national averages.

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and the national average of 76%.
- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 68% and the national average of 73%.
- 78% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 78% and the national average of 85%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them and telephone access did not seem to be a major concern. The patient participation group representative we spoke with said that practice had recently made significant improvements to telephone access.

Routine appointments with named GPs were available within two weeks. The practice was part of a locality group of practices which jointly provided an out of hours primary care service at weekends and evenings.

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.

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.

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.
- 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.

We looked at nine complaints (verbal and written) received in the last 12 months. Lessons were learnt from individual concerns and complaints and action was taken as a result

Good

Are services responsive to people's needs?

(for example, to feedback?)

to improve the quality of care, for example the protocol for offering priority appointments was reviewed in the practice meeting. Practice meetings included a standard agenda item on patient complaints.

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 vision was to improve the health of its patients by working in partnership with patients and with the other practices in its locality for the benefit of the community.

- The practice had a mission statement which was displayed in the waiting area and staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values and they were regularly monitored.
- The current practice partners had taken over the practice in 2014 and been forced to relocate. The practice had focused since then on improving its performance which had been poor. For example, the practice had improved its overall Quality and outcomes framework performance from 60% achievement in 2014/15 to 98.4% in 2015/16. The practice was now achieving above average performance on the management of some conditions, for example diabetes. This was an impressive turnaround which reflected well on the partners' clinical and managerial leadership. The practice had achieved this through a strategy of systematically focusing and improving performance on particular long term conditions in turn and a programme of staff training for the whole team.
- The practice had an action plan for those areas where it was still underperforming, for example A&E attendance rates.

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 in folders and on the shared drive.
- There was a comprehensive understanding of the performance of the practice. Benchmarking information was used to monitor practice performance in comparison to other practices within the same locality.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions.

Leadership and culture

The partners and senior staff in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised patient centred care and were able to provide examples and case studies. The partners and practice manager were accessible.

- There was evidence that changes to policies, guidelines, systems and processes were shared with staff.
- Staff said they felt respected, valued and supported by the partners, the lead GP and the practice managers. Staff consistently told us that the practice had improved in terms of the quality of the service and staff morale.
- The practice held regular staff meetings. Records of these meetings were kept for future reference. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issue at meetings or with managers individually.
- The provider complied 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).

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

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

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team.
- The practice had also gathered feedback from staff through appraisals and staff discussion.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

- There was a focus on learning and improvement at all levels within the practice. The practice sought feedback from staff and patients, which it acted on. The patient participation group was active and the practice was responsive. For example, the practice was aware that

Are services well-led?

Good

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

the geographical relocation had been difficult for longer standing patients. The practice had started in discussions with the council to assess the feasibility of opening a branch practice close to its original location.

- The practice partners were keen to work with the wider locality group of practices to influence the quality of commissioning and provision of care and access to services. One of the GP partners was the clinical director of the locality group's provider organisation.
- The practice was willing to experiment and trial new ideas to improve services. The practice had recently employed a clinical pharmacist to carry out medication reviews, carry out health checks and reviews of patients with long term conditions. This had proved to be beneficial in bringing pharmaceutical expertise into the practice and also enabling the GPs greater time to focus on patients with complex conditions. The practice had plans to expand the pharmacist role to provide a minor ailments service to practice patients and other patients in the locality.