Care UK - Hanley Health and Wellbeing Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Requires improvement
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 Care UK – Hanley Health and Wellbeing Centre on 8 February 2016. Overall the practice is rated as good, although caring services and the care provided for people whose circumstances make them vulnerable is rated as requires improvement.

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 Care Quality Commission (CQC) at that time.

Our key findings 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 practice had good facilities and was well equipped to treat patients and meet their needs.
- Risks to patients were assessed and well managed.
- Data detailing patient satisfaction levels was mixed. Registered patient satisfaction rates regarding interaction with GPs were lower than local and national averages.
- Registered patients said they found it easy to make an appointment with a named GP.
- There was a clear leadership structure and staff felt supported by the management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

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

Importantly, the provider must:

- Evaluate and where possible improve their performance in the national GP patient survey regarding registered patient satisfaction rates in relation to their interactions with GPs.

Summary of findings

There were areas of practice where the provider should make improvements.

- Improve internal processes to signpost appropriate patients with a learning disability to annual health assessments.
- Implement a system to alert staff to known vulnerable adults.
- Review the systems in place to maximise the opportunities to promote national screening programmes.
- Add a plan in partnership with the patient participation group to establish priorities of action for improvement and development of services.

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 there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and 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 the risk of abuse.

Are services effective?

Good

The practice rated as good for effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were around average for the locality and the national levels.
- Practice staff worked with other professionals to help meet the needs of their registered patients.
- Data for 2014/15 produced by the clinical commissioning group (CCG) showed that the number of registered patients admitted to hospital in an emergency was 32.1% higher than the CCG average. This area had been marked as an outlier for the last three years, although had shown a year on year decrease.
- There was evidence of appraisals and personal development plans for all staff.
- Clinical audits demonstrated quality improvement.

Are services caring?

Requires improvement

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

- Data showed that registered patients rated the practice lower than others for some aspects of care.
- The number of identified carers was lower than expected, although the practice had recognised this and were taking steps to improve the identification of carers.
- The practice conducted monthly satisfaction surveys for both registered and unregistered patients, which were more positive.

Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Registered patients could access services from 8am to 6:30pm five days a week.
- Unregistered patients could access services from 8am to 8pm 365 days a year.
- Data showed that registered patients were generally positive about access to appointments, with satisfaction levels in line with local and national levels.
- The practice saw around 620 unregistered patients each week.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?

Good

The practice is rated as good for being well-led

- The practice management team were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice team discussed patient feedback and made changes to services when required.

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 also offered all patients aged 75 and over a health check, with most taking place in the patient's home.
- 76% of patients aged 65 or over had received seasonal flu vaccinations. This was higher than the national average of 73.2%.

People with long term conditions

Good

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

- Patients at the highest risk to unplanned hospital admissions were identified and care plans had been implemented to meet their health and care needs.
- The practice had implemented a weekly long-term condition review clinic, in which patients had 30 minute appointments for combined checks with nursing staff and GPs.
- Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met.
- Data showed 77.3% of registered patients with asthma had a review of their condition within the previous year. This was higher than the CCG average of 75.2% and national average of 75.3%.

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 did not attend practice appointments or immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice offered contraceptive and sexual health advice for both registered and unregistered patients.

Working age people (including those recently retired and students)

Good

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

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

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

- The practice had 29 registered patients recorded with a learning disability. Staff were not clear on how any additional care needs of patients in this group were met.
- There was no system in place to alert staff to known vulnerable adults.
- Staff were unclear on how patients with a learning disability could access annual health checks.
- The care of other patients who circumstances who may make them vulnerable was discussed at internal practice meetings. Although the practice had recently introduced a system of arranging meetings with multi-disciplinary professionals to proactively review the care needs of patients in this group.

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).

- Data showed 93.5% of registered patients with severe poor mental health had a comprehensive care plan completed within the previous 12 months. This was higher than the CCG average of 86.4% and national average of 88.3%.

Summary of findings

- Data showed 83.1% of registered patients with dementia had a face to face review of their condition in the last 12 months compared with the CCG average of 85.1% and national average of 84%.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with seven patients (five registered and two unregistered) and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 29 completed cards.

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from the national GP patient survey published in January 2016. The survey invited 399 registered patients to submit their views on the practice, a total of 82 forms were returned. This gave a return rate of 21%.

The results from the GP national patient survey showed registered patients showed lower than average satisfaction rates on how they were treated by GPs and nurses. For example:

- 77% described their overall experience of the GP practice as good. This was lower than clinical commissioning group (CCG) average of 87% and national average of 85%.
- 67% said the GP was good at treating them with care or concern compared to the CCG average of 84% and national average of 85%.
- 87% had confidence in the last GP they saw or spoke with compared to the CCG average and national averages of 95%.
- 35% said that they usually get to see their preferred GP compared to the CCG average of 62.4% and national average of 60%.
- 85% said that the nurse was good at giving them enough time compared to the CCG average of 93% and national averages of 92%.
- 85% said the practice nurse was good at treating them with care or concern compared to the CCG average of 92% and national average of 91%.

Results from the national GP patient survey published in January 2016 showed mixed rates of registered patient satisfaction about access to appointments when compared to local and national averages:

- 82% of registered patients found it easy to contact the practice by telephone compared to the CCG average of 77% and national average of 73%.
- 93% of registered patients said the last appointment they made was convenient compared to the CCG average of 94% and national average of 92%.
- 58% of registered patients felt they did not have to wait too long to be seen compared to the CCG average of 60% and national average of 58%.
- 87% of registered patients were satisfied with the practice's opening hours compared to the CCG average of 80% and national average of 75%.
- 72% of registered patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.

Areas for improvement

Action the service MUST take to improve

- Evaluate and where possible improve their performance in the national GP patient survey regarding registered patient satisfaction rates in relation to their interactions with GPs.

Action the service SHOULD take to improve

- Improve internal processes to signpost appropriate patients with a learning disability to annual health assessments.
- Implement a system to alert staff to known vulnerable adults.
- Review the systems in place to maximise the opportunities to promote national screening programmes.
- Add a plan in partnership with the patient participation group to establish priorities of action for improvement and development of services.

Care UK - Hanley Health and Wellbeing Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a GP specialist advisor, a practice nurse specialist advisor (both with experience of GP practices and walk-in-centres) and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Care UK - Hanley Health and Wellbeing Centre

Care UK – Hanley Health and Wellbeing Centre is registered with the Care Quality Commission (CQC) as an organisational provider. The provider holds an Alternative Medical Provider Services (APMS) contract with NHS England to provide services to registered patients. The provider also holds an additional contract with NHS Stoke on Trent Clinical Commissioning Group (CCG) to provide appointments to unregistered patients on a walk in basis. Both contracts have been held since 2009 and are due for renewal in September 2016.

The locality is one of more than twice the level of deprivation when compared with the national average. At the time of our inspection the practice had 3,487 registered patients and this had grown at a modest rate since the service started. The demographic of registered patients differed from the national average. The practice has a much greater rate of patients aged 20 to 34 years when compared with local and national averages. Conversely the number of registered patients aged 45 -84 is significantly less than local and national averages.

The access for registered patients is from 8am to 6:30pm from Monday to Friday. Appointments can be made in person, by telephone or online for those who have registered to obtain services in this way.

The practice offers a walk in service for unregistered patients to be seen between 8am to 8pm 365 days a year. The definition of an unregistered patient is one who is registered with another, or no, GP. Practice records showed that the practice had seen 32,434 unregistered patients on a walk in basis during 2015. The commissioners of the service set out the range of expected conditions to be seen which includes a list of urgent and minor injuries and illnesses. Patients who are registered patients can access the walk in service and be classed at as unregistered patient, although there are bookable appointments for registered patients to be seen on the same day.

Registered patients see GPs or a member of the practice nursing team dependent on their preference or health need.

Unregistered patients are normally seen by a nurse practitioner during 8am to 6:30pm Monday to Friday, although after 6:30pm and at weekends one to two GPs assess and treat unregistered patients also. Data from the practice demonstrates that around 25% of unregistered patients are seen by a GP with the remaining 75% assessed by a member of the nursing team dependant on need.

Current staffing at the time of our inspection:

Detailed findings

- Four male GPs working differing hours although adding up to around two whole time equivalent (WTE).
- One male GP had been recruited on a full time basis in a lead capacity and was awaiting a start date.
- Vacancies of 2.62 WTE were covered by locum GPs.
- One male and one female nurse practitioners (registered nurses with extended training and independent prescribers).
- Vacancies of 1.25 WTE were covered by locum nurse practitioners.
- The wider practice nursing team consisted of a female practice nurse, assistant practitioner and two healthcare assistants. The practice also had a part time male practice nurse working on a part-time basis.
- The administrative team of 12 was led by a service and deputy service manager.
- Two members of cleaning staff.

The practice has opted out of providing cover to patients in the out-of-hours period. During this time services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

Why we carried out this inspection

We carried out the inspection 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.

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 our inspection we reviewed the information we held about the practice. We also reviewed intelligence including nationally published data from sources including NHS Stoke on Trent Clinical Commissioning Group, Public Health England and the national GP Patient Survey.

During the inspection we visited the practice. We spoke with members of staff including GPs, nurse practitioners, healthcare assistants, the service and deputy service managers, administrative, reception and cleaning staff. We gathered feedback from patients by speaking with them directly and considering their views on comment cards left in the practice for two weeks before the inspection.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. (Significant events can be described as a significant occurrence, which can be positive or negative, that leads to detailed analysis and learning to improve quality of care overall).

- 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.
- Significant events were recorded on a provider computer system for sharing on a wider basis.
- Staff met on a regular basis to share and discuss significant events at regular governance meetings.
- The practice carried out a thorough analysis of the significant events.
- The provider organisation used significant events for wider learning by publishing occurrences in a learning newsletter for all staff employed within the company.

The practice had recorded 21 significant events in the last year:

- Nine related to the whole practice.
- Four related to the provision of services for unregistered patients.
- Eight related to the provision of services for registered patients.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. One example of learning action was relocating staff involved in the processing of information about patients to a quieter area of the practice. This was to minimise the chance of interruptions and allowed them to concentrate on the task in hand.

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 the risk of abuse, which included:

- The practice had policies in place for safeguarding both children and vulnerable adults that were available to all staff on the practice computer system. The staff we spoke with knew their individual responsibility to raise any concerns they had and were aware of the appropriate process to do this. All the staff had received role appropriate training to nationally recognised standards, for example GPs had attended level three training in safeguarding children. The lead nurse practitioner was identified as the safeguarding lead within the practice and had attended level four safeguarding children training. They demonstrated they had the oversight of patients, knowledge and experience to fulfil this role. We saw examples of when staff had shared concerns with the relevant agencies and any actions had been clearly recorded. Computer alerts made clinicians aware of children with known safeguarding concerns, although similar alerts were not in place for vulnerable adults.
- Chaperones were available when needed, all staff who acted as chaperones had received training, been vetted and knew their responsibilities when performing chaperone duties. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. The availability of chaperones was displayed in the practice waiting room.
- The practice was visibly clean and tidy and clinical areas had appropriate facilities to promote current Infection Prevention and Control (IPC) guidance. IPC audits of the whole service had been undertaken regularly, this included staff immunity to healthcare associated infections, premises suitability and staff training/ knowledge.
- The practice followed their own procedures, which reflected nationally recognised guidance and legislative requirements for the storage of medicines. This included a number of regular checks to ensure medicines were fit for use. The practice nursing team consisted of an assistant practitioner, two healthcare assistants, two practice nurses and two independent nurse prescribers who had undertaken further training to prescribe medicines within their scope of practice. The practice nurses used Patient Group Directions (PGDs) to allow them to administer medicines in line with legislation. Healthcare assistants had received training to

administer certain medicines under specific circumstances. To enable this, the practice had a template to gain authorisation by a GP under a Patient Specific Direction (PSD). Blank prescriptions were stored securely, although the practice had not always tracked the issue of blank computerised prescription forms through the practice. We spoke with practice staff about this; they implemented a practice wide system of tracking blank computerised prescription forms during our inspection.

- We saw that patients who took medicines that required close monitoring for side effects had their care and treatment shared between the practice and hospital. The hospital organised assessment and monitoring of the condition and the practice prescribed the medicines required. A rolling cycle of safe prescribing audits was undertaken to ensure that patients that had received particular medicines had a computerised read code to indicate they had received the required monitoring in line with medicines guidance.
- We reviewed five personnel staff files and found
- The practice had a number of vacancies for clinical staff. Locum staff were given an appropriate induction to the practice including emergency procedures. Locum packs were also available in each clinical room.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- The practice had up to date fire risk assessments and carried out regular fire drills.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- Reception staff followed an algorithm for discreetly determining the nature of the condition when unregistered patients presented for an appointment. This was to screen for any 'red flag' conditions that may require immediate attention.
- Clinical staffing levels varied dependent on the time and day of the week. The practice management team demonstrated a good understanding of the staffing requirements of the service.
- Regular infection control audits were held and staff were immunised against appropriate vaccine preventable illnesses.
- The practice performed regular water temperature testing and flushing of water lines and had a written risk assessment for Legionella. (Legionella is a bacterium which can contaminate water systems in buildings).

Arrangements to deal with emergencies and major incidents

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

- All staff had received recent annual update training in basic life support.
- The practice had emergency equipment which included an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- Emergency medicines were held to treat a range of sudden illnesses that may occur within a general practice. All medicines were in date, stored securely and staff knew their location.
- An up to date business continuity plan detailed the practice response to unplanned events such as loss of power or water system failure.
- We saw an example of when a serious medical emergency involving a walk in patient had been discussed at a practice meeting. This was seen as an opportunity to review the procedures in place and had reinforced the effectiveness of them.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The staff we spoke with demonstrated a thorough knowledge of guidelines and care pathways relevant to the care they provided.

Changes to NICE guidance were not discussed at regular internal practice meetings, although changes were at wider meetings and had been cascaded from the provider organisation.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality 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). QOF results from 2014/15 showed:

- The practice achieved 92.9% of the total number of points available; this was lower than the national average of 94.7% and clinical commissioning group (CCG) average of 95%.
- Clinical exception reporting was 12.2%. This was worse than the national average of 9.2% and CCG average of 9%. Clinical exception rates allow practices not to be penalised, where, for example, patients do not attend for a review, or where a medicine cannot be prescribed due to side effects. Generally lower rates indicate more patients have received the treatment or medicine.
- Performance for the diabetes related indicators was lower than CCG and national averages. For example, 81.7% of registered patients with diabetes had received a recent blood test to indicate their longer term diabetic control was below the highest accepted level, compared with the CCG average of 84.5% and national average of 87%.
- 77.3% of registered patients with asthma had a review of their condition within the previous year. This was higher than the CCG average of 75.2% and national average of 75.3%.
- 83.1% of registered patients with dementia had a face to face review of their condition in the last 12 months compared with the CCG average of 85.1% and national average of 84%.
- 93.5% of registered patients with severe poor mental health had a comprehensive care plan completed within the previous 12 months. This was higher than the CCG average of 86.4% and national average of 88.3%.

The practice participated in a number of schemes designed to improve care and outcomes for patients:

- The Quality Improvement Framework (QIF) is a local programme with the CCG area to improve the detection and management of long-term conditions.
- The practice participated in the avoiding unplanned hospital admission enhanced service. Two per cent of registered patients, many with complex health or social needs, had individualised care plans in place to assess their health, care and social needs. Patients were discussed with other professionals when required and if a patient was admitted to hospital their care needs were reassessed on discharge.The care plans were available in the patient's home to enable other health professionals who may be involved in their care to have comprehensive information about them.
- The practice participated in a Local Improvement Scheme (LIS) arranged by the local CCG to offer health checks to registered patients aged 75 and over. The health checks were performed by both a GP and practice nurse/healthcare assistant and were offered to all patients in this age group. The majority had taken place in the patient's home. The practice had undertaken 152 health checks in a three month period. The health checks had highlighted concerns in some registered patients including increased risk of falls and emergence of previously undetected health conditions including hypertension (high blood pressure) and atrial fibrillation (irregular heart rhythm). Following assessment, appropriate action had been taken to manage any health risks identified. The practice had committed to extend this scheme to include patients in the age group of 65-74, as they felt it would also benefit patients in this demographic.

Good

Are services effective?

(for example, treatment is effective)

We looked at a number of outcomes for registered patients, including A&E attendance rates and rates of emergency admission to hospital. The practice was an outlier within the CCG area in a number of outcomes:

- Data for 2014/15 produced by the CCG showed that the number of registered patients admitted to hospital in an emergency was 32.1% higher than the CCG average. This area had been marked as an outlier for the last three years, although had shown a year on year decrease. In 2012/13 the practice performance had been 63% higher than the CCG average, therefore had nearly halved when compared with the 2014/15 data.
- Emergency admission rates to hospital for registered patients with a range of 19 conditions where effective management and treatment may have prevented admission was 37% higher than the national average. In 2012/13 the practice performance had been 42.6% higher than the CCG average; the 2014/15 data showed a modest reduction.

The practice was aware of higher than average admission rates and felt they could not be attributed to a single area. The practice felt that the actions they had implemented had led to an improved performance, although recognised further improvement was needed:

- The introduction of care plans under the avoiding unplanned admissions to hospital enhanced service.
- A practice had audited and understood the reasons for higher than average hospital admissions in registered patients.
- The practice had implemented a weekly long-term condition review clinic, in which patients had 30 minute appointments for combined checks with nursing staff and GPs.

We looked at data from 2014/15 from the NHS Business Services Authority on the practice performance on prescribing medicines:

- The average quantity of appropriate anti-inflammatory medicines was better than national and local levels.
- The published levels of prescribing data showed that the practice had previously had higher than average levels of prescribing hypnotic medicines. We reviewed more recent data which demonstrated that the practice prescribing levels had decreased to levels comparable with the CCG average.
- The average quantity of antibiotics prescribed was much higher than national averages. The number of antibacterial prescription items prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) was 1.28 compared with the national average of 0.27. STAR-PU allows more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.

Of note, it was not possible to determine if the higher than average prescribing levels related to the registered or unregistered patients as the computerised data could not be separated.

The practice showed us audits they had undertaken during 2015 regarding two common illnesses that may or may not need antibiotics, dependant on the symptoms and clinical findings.

Audits were discussed with the clinical team and the practice had antibiotic usage guidance in all clinical rooms for clinicians to refer to.

There had been five clinical audits undertaken in the last year, two of these were completed audits where the improvements made were implemented and monitored. The remaining three audits were awaiting their re-audit cycle with a date planned. The audits included that medicines had been prescribed appropriately and that the monitoring of medical conditions was appropriate. Audits had been discussed by the practice team and changes suggested to practice were made as needed.

Effective staffing

Staff at the practice were experienced and each brought specific knowledge to contribute to the delivery of care and treatment:

- The practice told us that it had been difficult to recruit GPs and nurse practitioners, although they had regular sessional GPs who worked on a part time basis. The former lead GP had provided clinical leadership whilst awaiting the appointment of a full time replacement lead GP.

Good

Are services effective?

(for example, treatment is effective)

- The practice nursing team was stable and included two nurse practitioners, practice nurses and healthcare assistants who had been supported to develop additional skills.
- The practitioners involved in the assessment of unregistered patients had received appropriate relevant training to allow them to undertake enhanced physical assessment.
- Staff told us they felt supported both by the leadership structure of both the organisation and within the practice.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The practice had a system for receiving information about patients' care and treatment from other agencies such as hospitals, out-of-hours services and community services. Staff were aware of their own responsibilities for processing, recording and acting on any information received. We saw that the practice was up to date in the handling of information such as discharge letters and blood test results.

The practice had a small number of identified patients who were approaching the end of their life. Previously the practice had discussed the care of patients in this group at monthly practice meetings, to which other professionals including the Integrated Locality Care Team (ILCT), community and palliative care nurses were invited. The practice had recently changed the process of the meetings to hold separate meetings to specifically discuss patients approaching the end of their life with other health professionals.

When patients were referred to hospital in either an emergency or urgent situation, relevant information was relayed to the receiving department by the provision of printed copies of referral letters. In most circumstances patients had the option to choose the hospital they wanted to receive planned treatment at and were guided through the process.

Requests for urgent referrals for registered patients who had symptoms that may be suggestive of cancer were tracked internally. This was to ensure the specialist appointment had been made for the patient to attend for assessment.

The practice provided details of assessment and treatment of unregistered patients who were given appointments at the practice. This was by providing a summary to the patients usual GP, normally on the same day.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Important decisions by patients about their wishes on when and when not to receive resuscitation were documented. The underlying process between clinician and patient for reaching the decision was in line with nationally recognised guidance.

Supporting patients to live healthier lives

Newly registered patients were offered a health assessment with a clinical member of staff when joining the practice.

The practice's uptake for the cervical screening programme was 74.5% which was lower than the CCG average of 79.9% and national average of 81.8%. Practice staff were aware of the lower than average performance in this area. The practice followed up patients who did not attend for screening.

Data from 2015, published by Public Health England, showed that the number of registered patients who engaged with national screening programmes was lower than local and national averages:

Good

Are services effective?

(for example, treatment is effective)

- 61% of eligible females aged 50-70 had attended screening to detect breast cancer .This was lower than the CCG average of 71.8% and national average of 72.2%.
- 45.1% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer. This was lower than the CCG average of 55.5% and national average of 57.6%.

The practice provided childhood immunisations and rates were mostly comparable to CCG and national averages. For example, 100% of children aged two had received the measles, mumps and rubella (MMR) vaccine. This was higher than the CCG average of 98.1%.

Seasonal flu vaccination rates for the over 65s were 76% compared with the national average of 73.2%.

The practice had 29 registered patients with a learning disability. The practice was not commissioned to provide annual health assessments for patients with learning disabilities. Although it is not compulsory for practices to provide annual health assessments, the purpose of them is to detect previously undiagnosed conditions that are more prevalent in this group. Staff were unaware of why the health checks would be needed and also at which location a patient may receive one.

The practice offered contraceptive and sexual health advice for both registered and unregistered patients with screening in certain circumstances for sexually transmitted infections.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed members of staff were courteous and very helpful to patients and treated them with dignity and 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 knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from the national GP patient survey published in January 2016. The survey invited 399 registered patients to submit their views on the practice, a total of 82 forms were returned. This gave a return rate of 21%.

The results from the GP national patient survey showed registered patients showed lower than average satisfaction rates on how they were treated by GPs and nurses. For example:

- 77% described their overall experience of the GP practice as good. This was lower than clinical commissioning group (CCG) average of 87% and national average of 85%.
- 67% said the GP was good at treating them with care or concern compared to the CCG average of 84% and national average of 85%.
- 87% had confidence in the last GP they saw or spoke with compared to the CCG average and national averages of 95%.
- 35% said that they usually get to see their preferred GP compared to the CCG average of 62.4% and national average of 60%.
- 85% said that the nurse was good at giving them enough time compared to the CCG average of 93% and national averages of 92%.
- 85% said the practice nurse was good at treating them with care or concern compared to the CCG average of 92% and national average of 91%.

Of note in the responses to the national GP patient survey was the number of registered patients who gave a response of poor to the questions asked about GPs and nurses. In the 10 questions asked, nine returned response levels of poor that were between half to four times higher than the CCG and national averages.

The practice was aware of the lower than average patient satisfaction scores and had discussed them at meetings and with the patient participation group (PPG). They felt the use of non-regular clinical staff impacted on registered patient experience. They felt recent stability in the recruitment of a full time GP and the use of regular part time GPs would improve patient satisfaction levels. The practice also proactively followed up 6% of both registered and non-registered patients each month by requesting they complete the Care UK Friends and Family Test. Results in this survey gave a higher level of satisfaction with on average 250 patients a month rating the practice in six outcomes including interaction with clinicians. The satisfaction score in the previous three months was commonly around 90%, although this did not measure the same questions as in the national GP patient survey.

We spoke with seven patients (five registered and two unregistered) and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 29 completed cards, of which all but one were positive about the caring and compassionate nature of staff. All of the patients we spoke with told us they were treated with care dignity, respect and understanding. We observed staff to be kind, warm and welcoming when interacting with patients and visitors. Three patients commented that the lack of continuity in clinical staff at the practice was a less positive experience of using the service.

Care planning and involvement in decisions about care and treatment

The GP patient survey information we reviewed showed lower satisfaction levels from registered patients in response to questions about their involvement in planning and making decisions about their care and treatment with GPs and nurses. The GP patient survey published in January 2016 showed;

Requires improvement

Are services caring?

- 58% said the last GP they saw was good at involving them about decisions about their care compared to the CCG average of 81% and national average of 82%.
- 67% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 86% said the last nurse they saw was good at involving them about decisions about their care compared to the CCG average of 87% and national average of 85%.
- 85% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.

We spoke with staff about this performance and they felt that the lower levels were due to recruitment issues with the lack of continuity of permanent clinicians. The practice had recruited a number of longer term clinicians and had the improvement of patient satisfaction on their action plan. The clinicians and wider staff members we spoke with gave positive examples of how they involve and support patients in such decisions.

Patient/carer support to cope emotionally with care and treatment

Patients gave positive accounts of when they had received support to cope with care and treatment. We observed staff to be supportive when dealing with patients.

The practice recorded information about carers and subject to a patient's agreement a carer could receive information and discuss issues with staff. At the time of our inspection the practice had 22 patients recorded as carers which was 0.69% of their registered patients. The practice was aware that the number of registered carers was lower than expected and had invited a local carers association to a practice meeting. The practice had invited the local carers association to hold monthly promotional stands in the reception area and had planned to implement a system of referring patients, with their consent, to the carers association.

If a patient experienced bereavement, practice staff told us that they were supported by a GP with access and signposting to other services as necessary.

Written information was provided within the waiting room to help carers and patients to access support services. This included organisations for poor mental health and advocacy services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a number of services to meet the needs of their registered patients:

- The practice provided planned weekly visits to two local care homes. Previously this had been under an extra commissioning arrangement. Although the arrangement had changed the practice had continued to provide the visits as they felt they were beneficial to patients.
- The practice had implemented longer appointments for registered patients in weekly long-term condition review clinics.
- Home visits were available for older patients and patients who would benefit from these.
- The practice was open and offered appointments to registered patients from 8am to 8pm each weekday.
- Practice staff were knowledgeable on how to arrange translation services
- The facilities were suitable for those with a disability.
- Online services enabled the booking of appointments and ordering of repeat medicines.

The practice had also been commissioned to provide additional appointments for unregistered patients. The arrangement consisted of the practice offering appointments each day to capacity with two nurse practitioners. Practice staff told us that since conception the practice had only needed to restrict access on one occasion due to severe demand pressures. Practice records showed that the practice had seen 32,434 unregistered patients on a walk in basis during 2015.

We reviewed the practice performance from 2014/15 in The Quality Improvement Framework (QIF) which is a local programme with the CCG area to improve the detection and management of long-term conditions. The data demonstrated more of the practice's registered patients presented at hospital Accident and Emergency (A&E) departments when compared with the CCG average:

- The overall number of registered patients self-presenting at A&E at any time was 69.6% higher than the CCG average.
- The number of patients self-presenting at A&E during GP opening hours was 51.9% higher than the CCG average.

The practice had audited registered patients A&E self-presentation during October to December 2015. The audit revealed that 54% were considered appropriate with the remaining attendances either considered inappropriate or out of practice opening hours. Of note, the percentage of patients referred to A&E by a GP was low at 0.8%. All inappropriate A&E attendances were followed up by a GP and registered patients were given signposting advice. The practice had identified registered patients who frequently self-presented at A&E and all had a personal care plan in place.

Access to the service

The practice was open from 8am to 8pm every day of the year. During these times the telephone lines and reception desk remained open.

Access for registered patients was:

- Monday to Friday 8am to 6:30pm.
- Appointments could be made in person, by telephone or online for those who had registered in obtain services in this way.
- Bookable same day appointments were released on a daily basis.
- Registered patients could walk in and wait to be seen in turn with non-registered patients.

Access for unregistered patients was:

- Every day from 8am to 8pm.
- Appointments could be made in person or by telephone.
- Unregistered patients self-presenting at the practice were given information on the waiting time to be seen.

Results from the national GP patient survey published in January 2016 showed mixed rates of registered patient satisfaction when compared to local and national averages:

- 82% of registered patients found it easy to contact the practice by telephone compared to the CCG average of 77% and national average of 73%.
- 93% of registered patients said the last appointment they made was convenient compared to the CCG average of 94% and national average of 92%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 58% of registered patients felt they did not have to wait too long to be seen compared to the CCG average of 60% and national average of 58%.
- 87% of registered patients were satisfied with the practice's opening hours compared to the CCG average of 80% and national average of 75%.
- 72% of registered patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.

The feedback we received from 36 patients was mainly positive about access to appointments. Three patients commented that the waiting time to be seen could be long, although the feedback did not indicate if this was for registered or unregistered patients.

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.

Information was available to help patients understand the complaints system and the complaints process was displayed on notice boards and a practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had received five complaints in the last 12 months. We tracked three complaints and saw they had been acknowledged, investigated and responded to in line with the practice complaints policy. There were no trends to the overall complaints received. Complaints were discussed with the Patient Participation Group (PPG), staff and at clinical meetings. Learning from complaints was evident and when appropriate the practice issued an apology and explained how systems had been changed to limit the risk of reoccurrence.

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 provider organisation had a written set of values and mission statement of 'fulfilling lives'. The staff we spoke with were aware of the values and mission statement and their role in applying them.

The practice fed into the provider organisation to provide assurance and monitoring that strategic priorities were met.

The practice was commissioned to provide the additional services for unregistered patients until September 2016. The future direction of the service was under review by the commissioners. Staff were hopeful that the practice would continue to expand and develop, although were waiting for confirmation on how future services would be provided.

Governance arrangements

Both the practice and provider organisation had thorough oversight of governance issues to support the delivery of strategy of quality care.

- Practice staff were clear about their own roles and demonstrated a good knowledge of their individual performance.
- Risks from disruption to services from unplanned events such as emergencies and risks from equipment and premises were comprehensively and well managed.
- The practice had up to date policies and procedures for staff to refer to for guidance.
- The practice held regular meetings to discuss governance issues such as significant events, medicine safety alerts and changes to guidance.
- The practice participated in the Quality and Outcomes Framework (QOF) for their registered patients and had achieved high results.
- The governance team of the provider organisation conducted remote quality checking of patient care using searches of records. This action was undertaken on a monthly basis to ensure care and monitoring had been given in line with national recognised guidance.
- The practice used a number of locum clinical staff due to staffing vacancies. The induction process for non-permanent staff had been developed by practice staff. This was to give relevant information to enable clinicians to perform their role effectively.

The practice felt their biggest challenge to performance was the reliance on non-permeant clinical staff. The practice and provider organisation had undertaken recruitment campaigns to attract clinicians to work within the service. There had been some success as they had recruited a full time GP to work in a lead capacity and had relatively stable staffing in the nursing team.

Leadership and culture

All of the staff we spoke with told us that they felt supported by the leadership team both within the practice and provider organisation. They told us that the leadership team were visible, approachable and all enjoyed working at the practice.

The practice had previously had a lead GP to manage clinical governance within the practice. Due to individual circumstances they had no longer been able to continue in the role, although had been able to work in an acting lead capacity. We spoke with the GP; they had a good understanding of the demographical and operational needs of the practice. Staff described the acting lead GP as approachable and involved. A replacement lead GP had been recruited and was planned to transition into the role in the coming months.

When there were unexpected or unintended safety incidents, the practice gave affected people reasonable support, truthful information and a verbal and written apology.

Staff told us that they felt supported and able to make suggestions to how the practice provided services. All staff had received recent appraisals.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a patient participation group (PPG). Staff and the PPG met to discuss the practice. We spoke with two members of the PPG who told us they felt well supported and listened to although they felt the practice did not give the group clear direction on areas they wished them to concentrate on. The numbers of PPG members

Are services well-led?

Good

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

had decreased in recent years, although the practice had attempted to attract new members by promoting the PPG group in reception, on social media and on new patient registration forms.

The practice asked at least 6% of both registered and unregister patients who had used the service in the previous month to complete the Care UK Friends and Family test.

We saw that practice considered the views of patients in quality assurance meetings and had acted on less positive comments, for example adding more pre-bookable on the day appointments in response to comments by registered patients.

Staff told us they felt able to make suggestions to services provided at the practice.

Management lead through learning and improvement

The staff we spoke with told us they felt supported to develop professionally. Staff from both clinical and administrative staff groups told us they had been encouraged and supported to gain new skills and qualifications.

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 provider did not have an adequate process for assessing, monitoring and improving the quality of services provided in the carrying on of the regulated activity (including the quality of experience of service users in receiving those services) in relation to evaluating the reasons for the performance data detailed below.** **Data from the national GP patient survey published in January 2016 showed patient satisfaction levels were lower than local and national averages:** • 67% said the GP was good at treating them with care or concern compared to the clinical commissioning group (CCG) average of 84% and national average of 85%. • 58% said the last GP they saw was good at involving them about decisions about their care compared to the CCG average of 81% and national average of 82%. • 67% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%. • 67% said the GP was good at treating them with care or concern compared to the CCG average of 84% and national average of 85%. 17 (2) (a) (f)