Dr Pearl Chin

Quality Report

Westbourne Grove Medical Centre
241 Westbourne Grove
London W11 2SE
Tel: 020 7229 5800
Website: www.westbournegrovemedical.co.uk

Date of inspection visit: 6 August 2015
Date of publication: 05/11/2015

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 'Dr Pearl Chin', also known as Westbourne Grove Medical Centre, on 6 August 2015. Overall the practice is rated as good.

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.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Recruitment checks were carried out prior to employment, although we found that non-clinical staff acting as chaperones had not received a disclosure and barring check (DBS). Following our inspection the practice provided evidence that DBS checks had been carried out for these staff.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.

Summary of findings

However there was an area of practice where the provider needs to make improvements.

Importantly the provider should:

- Advertise that translation services are available to patients on request.
- Be proactive in seeking the views of patients through the patient participation group.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Recruitment checks had been carried out prior to employment, although we found that some non-clinical staff who acted as chaperones had not received a disclosure and barring check (DBS). Following our inspection the practice provided evidence that DBS checks had been carried out for non-clinical staff who acted as chaperones.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We 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. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same

Summary of findings

day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice monitored feedback from patients and staff, which it acted on. There was a patient participation group, however uptake was low and the practice were actively trying to recruit more members to the group.

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 had a lower percentage of patients over the age of 75 (2.7% compared to the national average of 7.6%), and patients over the age of 85 (0.6% compared to the national average of 2.2%). The income deprivation level affecting older people was 29 compared to the national average of 22.5.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients over the age of 75 had a named GP and were informed of this. The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, which included offering the shingles vaccination and avoiding unplanned admissions to hospital. Monthly multidisciplinary team meetings were used to review care plans and discuss those with enhanced needs. The practice were responsive to the needs of older people, and offered longer appointments, home visits and rapid access appointments for those with enhanced care needs. Patients were reviewed following discharge from hospital and referrals to support services, such as the rapid response team, were made to prevent readmissions.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The percentage of patients at the practice with a long standing health condition (41.6%) was lower than the national average (54%). The percentage of patients with health related problems in daily life (32%) was also lower than the national average (48.8%).

The GPs and nurse were responsible for chronic disease management, and patients at risk of hospital admission were identified as a priority. These patients had structured annual reviews to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. For example the link pharmacist, who saw patients at the practice, performed medicines reconciliation on all unplanned admissions to hospital and medicines optimisation for patients that had complex polypharmacy. Longer appointments and home visits were available when needed.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Children aged zero to four represented 5.9% of the practice population (national average 6.0%); children aged five to 14 represented 8.9% (national average 11.4%); and those aged under 18 years represented 10.6% (national average 14.8%). The income deprivation level affecting children was 28 compared to the national average of 22.5.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children on the child protection register. We saw examples of joint working with the health visitor who attended the monthly multidisciplinary meeting to discuss vulnerable children. Urgent access appointments were available for children who were unwell. Immunisation rates for standard childhood immunisations were similar to or above the CCG averages. Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school hours. The practice provided antenatal and postnatal care, and extra time was allocated for these appointments.

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 age profile of patients at the practice was mainly those between 25 and 49 years. The number of patients in paid work or full-time education was above the national average, 69.2% compared to 60.2%.

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. Access to the practice was rated highly by patients when compared to CCG and national averages. The practice had a website which offered facilities to book appointments and order repeat prescriptions online. Late appointments were prioritised for working patients, and telephone consultations were available at the end of each clinical session. There was a full range of health promotion and screening that reflected the needs for this age group. The practice's uptake for the cervical screening programme was 83%, which was above the CCG average of 77.4% and similar to the national average of 82%. The GPs and nurses offered opportunistic sexual health screening, and patients were provided with information and signposted to local genitourinary medicine (GUM) services.

Summary of findings

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 housebound patients, carers, those with a learning disability, and patients receiving end of life care. Longer appointments were offered to patients with a learning disability, and these patients were offered an annual health check. Housebound patients and those who could not access the practice were supported via home visits. The practice worked with multi-disciplinary teams in the case management of vulnerable people. The clinical team also met with a primary care navigator, who saw patients over the age of 55 with complex social needs, for advice in supporting vulnerable patients. The practice had a high prevalence of transgender patients with complex needs, and clinical staff were sensitive to the needs of these patients. The practice had a small population of patients with drug and alcohol problems. All new patients had an alcohol score recorded which allowed clinical staff to prioritise a response, and refer to the appropriate community support services. 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). Overall performance for mental health related indicators was below the CCG and national averages. However, 92% of people experiencing severe mental illness had a comprehensive care plan documented and this was above the CCG (83.6%) and national averages (85.9%). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients on long-term injectable medicines for mental health conditions could see the practice nurse for depot administration (special preparation of the medicine which is given by injection). Patients could be referred to a counselling and psychotherapy service, and the practice had access to the community mental health team for more complex or severe mental illness. A community psychiatric nurse (CPN) offered a weekly session at the practice and staff could refer directly to the CPN, who was able to review patients' medicines during their appointment.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.	

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above local and national averages. There were 76 responses which represented 1.04% of the practice population.

- 98% find it easy to get through to this surgery by phone compared with a CCG average of 85% and a national average of 73%.
- 97% find the receptionists at this surgery helpful compared with a CCG average of 86% and a national average of 87%.
- 94% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.
- 98% say the last appointment they got was convenient compared with a CCG average of 91% and a national average of 92%.
- 88% describe their experience of making an appointment as good compared with a CCG average of 79% and a national average of 73%.
- 76% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 65% and a national average of 65%.
- 70% feel they don't normally have to wait too long to be seen compared with a CCG and national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards which were mostly positive about the standard of care received. Patients said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment.

Areas for improvement

Action the service SHOULD take to improve

- Advertise that translation services are available to patients on request.
- Be proactive in seeking the views of patients through the patient participation group.

Dr Pearl Chin

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor. The specialist advisor was granted the same authority to enter the registered persons' premises as the CQC inspector.

Background to Dr Pearl Chin

Dr Pearl Chin, also known as Westbourne Grove Medical Centre, provides GP led primary care services through a Personal Medical Services (PMS) contract to around 7,300 patients living in the surrounding areas of Notting Hill. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS West London (Kensington and Chelsea, Queen's Park and Paddington) Clinical Commissioning Group (CCG).

The practice staff comprise of a female GP principal; two male and one female salaried GPs; a practice nurse, two health care assistants (HCA); a practice manager; and a small team of reception/administrative staff. Two regular GP locums are used to cover clinical sessions. The GPs collectively cover 36 sessions. The practice nurse works 29.5 hours per week, and the HCAs work ten hours between them.

The practice is located over four floors in the building. The ground floor has a reception office, waiting room, and three consulting / treatment rooms (two of which are step free). The mezzanine level and first floor have three consulting / treatment rooms. The second floor has a counsellor's room. The third floor and basement are used for administration and meetings. Access to the practice is via the ground floor entrance, and it is the ground floor only which is accessible by wheelchair.

The practice is open every weekday from 08:00 to 18:30, with the exception of Wednesday afternoon when it closes at 16:30. Appointments are available between 09:00 to 12:00 for morning sessions and 16:00 to 18:00 for evening sessions. Patients can speak to a doctor or nurse between 12:30 to 13.00 or 14.00 to 15.30 during opening hours. Appointments can be booked six weeks in advance over the telephone, online or in person. The practice opted out of providing out-of-hours services to their patients. Outside of normal opening hours and from 16:30 on Wednesday afternoon, patients are directed to an out-of-hours GP, or the NHS 111 service.

The practice has a predominantly young adult population between the ages of 25 and 49. The number of patients aged zero to four (5.9%) is similar to the national average (6.0%). There is a lower percentage of patients aged five to 14 (8.9%) and under 18 (10.6%) when compared to national averages (11.4% and 14.8% respectively). There is a lower percentage (than the national average) of people with a long standing health condition (41.6% compared to 54%), and a lower percentage of people with health related problems in daily life (32% compared to 48.8%). The average male and female life expectancy for the CCG area is 81 for males and 85 for females (national averages 79 and 83 respectively).

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures; treatment of disease, disorder and injury; and maternity and midwifery services.

Detailed findings

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. The provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 6 August 2015. During our visit we spoke with a range of staff including: the GP principal; two salaried GPs; a GP locum; the practice nurse; a health care assistant; the practice manager; and a receptionist. We also spoke with a pharmacist who is attached to the practice. We spoke with five patients who used the service, and received feedback from three members of the patient participation group. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 30 comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. Complaints received by the practice were treated as significant events. The practice carried out an analysis of the significant events.

The practice kept records of significant events since 2005, with approximately three to six events documented per year. We reviewed these records and saw that lessons were shared to make sure action was taken to improve safety in the practice. For example, the email address of a patient participation group (PPG) member had been used by a patient as a form of contacting the practice for appointments. This was treated as a significant event due to a potential breach of confidential personal information being sent to a non NHS email account and to someone other than an employee of the practice. The practice investigated factors which may have led to this event, updated the practice website to remove information which may be misleading for patients, contacted the patient regarding the incident, and shared this learning with staff.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- Notices were displayed in the waiting rooms and on consultation room doors, advising patients that a chaperone service was available if required. All staff who acted as chaperones had received training for the role, however the practice had not carried out a risk assessment to identify whether the non-clinical staff who acted as chaperones required a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Following our inspection the practice provided evidence that DBS checks had been carried out for three non-clinical staff who acted as chaperones.
- There were procedures in place for monitoring and managing risks to patient and staff safety. A health and safety policy was available and a risk assessment had been carried out in March 2015. The practice had up to date fire risk assessments, fire marshals were appointed, staff had received annual fire safety training, and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as electrical installation, infection control, legionella, and asbestos.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result of the last audit in May 2015. For example, all privacy curtains had been replaced and hand washing technique signs were now on display in all consulting rooms. The practice had also met with the cleaning company manager to discuss other issues identified, and as a result a supervisor from the cleaning company was due to carry out spot-checks on the quality of work carried out by the cleaning staff.

Good

Are services safe?

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the five files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service for clinical staff.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff to cover each other's annual leave to ensure that enough staff were on duty. Locum GPs who were known to the practice also covered clinical sessions when needed.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training. The practice had a defibrillator and medical oxygen available on the premises. 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 monitored, in date and fit for use.

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 carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. There were systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 88.5% of the total number of points available, with 7% exception reporting. This was similar to the clinical commissioning group (CCG) average (89%) and lower than the national average (93.5%). Data from 2013/14 showed;

- Performance for diabetes related indicators was similar to the CCG and national averages (practice 87.6%; CCG 86.4%; national 90.3%). Examples of the practice's performance included patients with diabetes who had a blood pressure reading in the preceding 12 months of 150/90 mmHg or less (practice 93.2%, CCG 90.9%, national 91.7%); patients with diabetes with a record of a foot examination and risk classification within the last 12 months (practice 84.2%, CCG 88.5%, national 88.3%); and patients with diabetes who had received the seasonal flu vaccination (practice 80.7%, CCG 88.9%, national 93.4%).
- Performance for hypertension related indicators was above the CCG and national averages (practice 100%; CCG 87.2%; national 88.4%). Examples of the practice's performance included patients with hypertension who had a blood pressure reading in the preceding nine months of 150/90 mmHg or less (practice 85.5%, CCG 80.8%, national 83.1%); and patients aged 79 or under with hypertension who had a blood pressure reading in the preceding nine months of 140/90 mmHg or less (practice 80.8%, CCG 73.5%, national 75.3%).
- Performance for mental health related indicators was below the CCG and national averages (practice 77.2%; CCG 85.2%; national 90.4%). Examples of the practice's performance included patients with schizophrenia, bipolar affective disorder and other psychoses, who had a comprehensive care plan documented (practice 92.1%, CCG 83.6%, national 85.9%); and patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who had a cholesterol blood test in the preceding 12 months (practice 56.7%, CCG 77.6%, national 79.5%). We were shown data from the QOF 2014/15, which showed the practice had improved their performance for mental health related indicators by achieving 96%.
- Performance for dementia related indicators was below the CCG and national averages (practice 80.2%; CCG 90.5%; national 93.4%). Examples of the practice's performance included patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (practice 100%, CCG 83.2%, national 83.8%). We were shown data from the QOF 2014/15, which showed the practice had improved their performance for dementia related indicators by achieving 100%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been two completed clinical audits completed in the last 18 months, where the improvements made were implemented and monitored. We reviewed an audit on INR blood testing in patients treated with the medicine warfarin. The initial audit had been carried out in March 2014, and a re-audit took place in August 2014. The initial audit showed that 45% of patients had their INR level recorded within the agreed time. Action taken included ensuring all requests for repeat prescriptions had the patient's current blood test result, and reaffirming with patients what was expected of them in terms of attendance for testing. The re-audit showed that 55% of patients now had their INR recorded. The practice recognised that there were still further improvements to be made. The practice participated in applicable local audits, benchmarking and peer review. Findings were used by the practice to improve services. For example, recent action taken included

Good

Are services effective?

(for example, treatment is effective)

reviewing the renal function of patients before prescribing a particular medicine in line with guidance from the Medicines and Healthcare products Regulatory Agency (MHRA).

Effective staffing

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

- The practice had an induction programme for newly appointed members of staff that covered health and safety information and guidance on the practice's policies. A comprehensive GP locum pack was also available and covered topics such as safeguarding, referrals, and prescribing.
- 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 these learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, appraisals, mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety, basic life support, infection control, and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service electronically, by post or by fax. Out-of-hours reports, 111 reports and urgent pathology results or letters were seen and actioned the same day. The GP who saw these documents and results was responsible for the action required. There was a process for reviewing correspondence and staff we spoke with were familiar with this. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings, attended by a district nurse, community pharmacist, and primary care navigator, took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

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

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives (four patients), carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. All new patients had an alcohol score recorded which allowed clinical staff to prioritise a response, and refer to the appropriate community support services. A health care assistant and a visiting smoking cessation advisor offered smoking cessation clinics twice a week. Patients were also signposted to relevant services. For example, patients who were obese could be referred to a dietician, a weight management support group, or specialist bariatric services.

Good

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 83%, which was above the CCG average of 77.4% and similar to the national average of 82%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to the CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 73.3% to 88% (CCG 73.7% to 80.7%), and five year olds from 47.7% to 85.2% (CCG 64.1% to 87.1%). The practice nurse monitored and followed up children who had not attended for their vaccinations. Flu vaccination rates for the over 65s was 60.71% (national average 73.24%), and at risk groups 43.5% (52.29%).

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Patient feedback received by the practice showed they requested soundproofing in the ground floor waiting room, and whilst the practice were looking into carrying out this work music was played in the waiting rooms. We noted that consultation and treatment room doors were closed during consultations and that 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 area to discuss their needs.

The five patients we spoke with provided mostly positive feedback about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. The 30 CQC comment cards we reviewed highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey 2015 showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with the doctors and nurses, and the helpfulness of reception staff. For example:

- 97% said the GP was good at listening to them compared to the CCG and national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 85% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 98% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.
- 97% patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 73%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey 2015 we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

• 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.

• 90% said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 81%.

Staff told us that translation services were available for patients who did not have English as a first language. However, we did not see notices informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The percentage of patients with a caring responsibility was lower than the national average, 15.3% compared to 18.2%. The practice's computer system alerted GPs if a patient was also a carer and they were supported, for example by offering the flu vaccination and referral to the primary care navigator for further support. Written information was available for carers to ensure they understood the various avenues of support available to them.

All staff received a notification if a patient had passed away. Staff told us that if families had suffered bereavement they

Good

Are services caring?

were referred to or given advice on how to access support services. For example, patients could be referred to a bereavement service, and information on charitable organisations was available in the waiting room.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice had started planning for the 'out-of-hospital services' whereby additional services were offered to patients within the GP practice environment.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- Longer appointments were available for people with a learning disability, those with mental health conditions, patients with multiple conditions, the elderly, and for appointments where an interpreter was required.
- The nurse offered longer appointment slots for travel immunisations, spirometry, wound dressing, and health checks.
- Patients on long-term injectable medicines for mental health conditions could see the practice nurse for depot administration (special preparation of the medicine which is given by injection).
- Urgent appointments were available for patients aged over 75 and under 18 years.
- Home visits were available for older patients, those who were housebound, and patients who would benefit from these.
- The practice was based in a building which was constructed prior to any compliance towards the Disability and Discrimination Act (DDA). This meant the premises could not be adapted to fully meet the needs of people with disabilities. Patients with mobility difficulties or those who used wheelchairs were seen in the two consulting rooms on the ground floor.
- Accessible toilets and baby changing facilities were available.
- Translation services were available online, over the phone, or in person.
- The practice had a high prevalence of transgender patients with complex needs, and clinical staff were sensitive to the needs of these patients.
- Patients could access a male or female GP.
- Staff told us they tried to be flexible by avoiding booking appointments at busy times for people experiencing poor mental health or who may find this stressful.

Access to the service

The practice was located over four floors in the building, with the ground floor only accessible by wheelchair. The practice was open every weekday from 08:00 to 18:30, with the exception of Wednesday afternoon when it closed at 16:30. Appointments were offered between 09:00 to 12:00 for morning sessions and 16:00 to 18:00 for evening sessions. Appointments could be booked up to six weeks in advance over the telephone, online or in person. Urgent appointments were also available for people that needed them, and information on the appointment system could be found in the practice leaflet and website. Outside of normal opening hours patients were directed to an out-of-hours GP, or the NHS 111 service.

Results from the national GP patient survey 2015 showed that patients' satisfaction with how they could access care and treatment was comparable to or above the local and national averages, and most people we spoke to on the day were able to get appointments when they needed them. For example:

- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 98% of patients said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 73%.
- 88% of patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 76% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 65%.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. For example, information was included in the practice leaflet and posters were displayed in the waiting rooms. Patients we spoke with were not aware of the process to follow if they wished to make a complaint, however they told us they felt comfortable requesting the information from staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, urgent prescription requests were given directly to a GP following a complaint where an urgent request had been delayed. All complaints had been written up as significant events and learning from this was shared with staff during clinical or whole practice meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This strategy included providing a high quality service which was accessible, flexible and responsive to the practice population. The 'out-of-hospital services' were a priority for the practice and were incorporated into their strategy. For example, the role of the health care assistant was being extended to assist with out-of-hospital services such as phlebotomy. Staff we spoke with knew and understood the practice's vision and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a 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.
- There was a comprehensive understanding of the performance of the practice.
- Recruitment in key areas such as reception and nursing were a priority for the practice to promote good outcomes for patients. The practice were actively seeking to recruit a second nurse, and health care assistants were being trained to assist nursing staff with duties including health checks, electrocardiograms (ECG), and minimal wound care.
- Clinical audits were used to monitor quality and to make improvements.
- The Quality and Outcomes Framework (QOF) was used to measure the practices performance, and clinical staff were allocated a particular QOF domain to lead on.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

The GP principal and practice manager had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. They were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The management encouraged a culture of openness and honesty.

Regular team meetings were held. All staff met every morning prior to the practice opening for informal discussions. This was in addition to the weekly clinical meetings, and weekly practice lunch meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to develop the practice, and the management encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice valued feedback from patients and monitored patient feedback via the national GP patient survey, the friends and family test, a comments box in reception, and complaints received. Results from the friends and family test in May 2015 showed that 92% of respondents were likely to recommend the practice and 6% were unlikely to. In June 2015 96% were likely to recommend the practice and 4% were unlikely to, and in July 2015 100% of respondents were likely to recommend the practice. We saw from records that patient feedback and how the practice were performing was shared with staff on a monthly basis to continually improve the service. We were told that the practice took action on feedback received. For example, patients had previously commented on the décor of the practice and so the practice had been redecorated. Patients commented on the limited space in the two waiting rooms on the ground and first floor, however the practice were limited on increasing space due to the layout of the building. Patients also commented on soundproofing in the ground floor waiting room, and the practice were obtaining quotes for this work to be done. In the interim music was played in both waiting areas.

The practice had set up a patient participation group (PPG), however uptake to the group was low. The practice were trying to recruit members to the PPG by encouraging patients to join when they visited the practice, and advertising on the website and in the waiting room. We received feedback from three PPG members who spoke

Are services well-led?

Good

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

positively about the service. One person told us that recruitment to the group had been slow and they were not aware of any meetings that had taken place so far, the other two were new members to the group.

The practice had also gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

The practice encouraged continuous learning and improvement at all levels within the practice. For example, the practice had supported a receptionist to undertake training as a health care assistant and they were currently being mentored by the practice nurse.