Faith House Surgery

Quality Report

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Date of inspection visit: 13 June 2016
Date of publication: 09/11/2016

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Faith House Surgery on 13 June 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw areas of outstanding practice:

- The practice had established pathways to provide holistic care for older people that included consideration of their social needs. For example, clinical staff worked one-to-one with patients to implement preventative health promotion strategies in their everyday lives to reduce the risk of falls, fractures

and pneumonia. Staff were proactive in maintaining contact with such patients and actively encouraged them to seek help and advice in a way that empowered them and reduced the risk they would not contact the practice for fear of wasting staff time.

- The practice had introduced a new clinical role, an urgent care practitioner, led by a qualified paramedic. This member of staff provided additional capacity to treat a number of illnesses and injuries. This meant patients had more rapid access to appointments and provided GPs with more capacity to see patients with complex needs.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients 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 saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the clinical commissioning group to secure improvements to services where these were identified.
- Patients said they the practice provided continuity of care, with urgent appointments and home visits available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. Due to short staffing, practice nurses had not always participated in clinical governance meetings. However, the senior team used a new planned clinical governance framework alongside the workforce strategy to address this.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels, which were used to promote innovation in how staff work and to ensure the service was sustainable.

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 and provided this within an understanding of the relative levels of deprivation and risk of social isolation in the local area.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. Clinical staff provided care for 66 patients in 12 residential care homes and conducted regular visits to ensure the needs of all patients were met.
- There was a continual focus on working with older people to improve their health and wellbeing through preventative measures and health promotion strategies. This included a holistic approach to ensuring patients were empowered to raise social issues and concerns and to speak to clinical staff without worrying about taking up their time.
- Clinical staff worked one-to-one with patients to implement preventative health promotion strategies in their everyday lives to reduce the risk of falls, fractures and pneumonia.
- Practice nurses offered annual healthy heart checks and the practice offered dementia and cognitive screening for older people.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Staff proactively contacted patients who missed appointments to ensure continuous care was provided.

Summary of findings

- The practice engaged with district nurses and a palliative care consultant to ensure end of life care was provided in line with the Gold Standards Framework.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances. Children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Antenatal clinics were available and staff offered postnatal check ups.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. This included nurse-led health checks and active follow-up and recall for cervical screening.
- The practice offered sexual health guidance and referrals and health checks tailored to the needs of students.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Such

patients were offered longer appointments and annual health checks. The practice also monitored patients who were at risk of accident and emergency attendances and offered regular health checks to help them access more appropriate care.

- The practice regularly worked with other health care professionals in the case management of vulnerable patients, including social services and specialist doctors.
- Staff demonstrated attention to detail in identifying the vulnerabilities that could affect patient's safety and wellbeing. For example, a member of staff had arranged for the fire service to work with a patient one-to-one in their home to make it safe after they became concerned about safety during a home visit.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. There was evidence staff had taken appropriate rapid action in cases where they suspected a young person was at risk.
- A partner had undertaken PREVENT training in line with Home Office standards, which enabled them to ensure the practice reacted appropriately to evidence of child radicalisation. This training was being delivered to all practice staff along with clinical training on supporting patients who had undergone female genital mutilation.
- The practice maintained a list of patients with needs relating to drug use, including those prescribed methadone. A partner had undertaken specialist training to be the named lead for the patients and provided holistic care and support to them alongside a drug liaison worker, who attended the practice twice weekly. Patients were able to see a doctor on an ad-hoc basis, which meant they could be seen during a time of crisis or elevated need.

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).

- 88% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which was better than the national average of 84%.

Summary of findings

- 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had a documented care plan in the last 12 months, which was better than the national average of 88%.
- 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the last 12 months, which was better than the national average of 90%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. This included working with community mental health teams to provide at-home support to patients in crisis.
- The practice carried out advance care planning for patients with dementia using memory assessment tools.
- The practice supported patients experiencing poor mental health to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing abovelocal and national averages. 246 survey forms were distributed and 118 were returned. This represented 1.5% of the practice's patient list.

- 86% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group (CCG) average of 68% and the national average of 73%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 70% and the national average of 76%.
- 93% of patients described the overall experience of this GP practice as good compared to the CCG average of 83% and the national average of 85%.
- 79% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 28 comment cards which were all positive about the standard of care received.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Outstanding practice

- The practice had established pathways to provide holistic care for older people that included consideration of their social needs. For example, clinical staff worked one-to-one with patients to implement preventative health promotion strategies in their everyday lives to reduce the risk of falls, fractures and pneumonia. Staff were proactive in maintaining contact with such patients and actively encouraged them to seek help and advice in a way that empowered them and reduced the risk they would not contact the practice for fear of wasting staff time.
- The practice had introduced a new clinical role, an urgent care practitioner, led by a qualified paramedic. This member of staff provided additional capacity to treat a number of illnesses and injuries. This meant patients had more rapid access to appointments and provided GPs with more capacity to see patients with complex needs.

Faith House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an Expert by Experience.

Background to Faith House Surgery

Faith House Surgery, 723 Beverley Road, Hull, HU6 7ER has a clinical team of three GP partners, one of who is male and two are female. There are two practice nurses, an urgent care practitioner who is also a paramedic, a healthcare assistant and a phlebotomist. It is a teaching practice with regular intakes of foundation level two doctors and regularly uses locum doctors. A practice manager and IT manager are in post and are supported by secretaries, a summariser and a team of receptionists and administrators.

The practice has baby changing facilities and promotes a positive environment for breast feeding. Accessible toilets are available and patient wifi access is available in the waiting areas. Patients can check-in using a self-service kiosk, which provides guidance in multiple languages or at the manned reception desk. The practice has two floors and a wheelchair-accessible lift is available.

The practice serves a patient list of 7,672, including 150 registered carers and is in an area of deprivation.

Appointments are from 8.30am to 6pm Monday to Friday and from 9am to 12.45pm on Saturdays.

54% of patients are of working age, compared to the England average of 67%. The practice has a lower number of patients with a long-standing health condition 50% compared with a national average 54%.

We had not previously carried out an inspection at this practice.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 June 2016. During our visit we:

- Spoke with a range of staff, including clinical and non-clinical staff, spoke with patients who used the service and members of the patient participation group.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Detailed findings

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Between June 2015 and June 2016, there had been nine recorded incidents. The senior GP partner and the practice manager investigated all incidents, which staff submitted using the practice's electronic system. The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a root cause analysis of significant events in clinical meetings although there was not a robust or systematic process for the dissemination of findings. For example, these could be discussed in ad-hoc meetings or communicated by e-mail. The practice had established procedures for ensuring incidents that involved other services, such as hospital services, were investigated and followed-up.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. A dedicated prescribing lead acted on medication alerts and conducted an audit of patient lists when an alert was issued.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding children and adults.
- 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 on safeguarding children and vulnerable adults relevant to their role. All GPs were trained to child protection or child safeguarding level three and a GP partner had completed PREVENT training to help identify the early signs of radicalisation. This member of staff had begun to deliver the training programme to the rest of the practice team. All staff in the practice had adult safeguarding training and child safeguarding level one training. 41% of staff had more advanced child safeguarding level 2 training.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection control protocol in place and staff had received up to date training. Some areas of the practice were carpeted and there were also seats with cloth coverings on them. These were steam cleaned in line with national guidance.
- A practice nurse was the infection control clinical lead who liaised with local infection prevention teams to keep up to date with best practice.
- The last annual infection control audit had taken place in 2013. The practice manager had implemented a new infection control toolkit that would be used to conduct regular infection control audits.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk

medicines. The practice carried out regular medicines audits, with the support of the local CCG medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

- Patient Group Directions (these are written directions which allow specified healthcare professionals to administer medicines in the absence of a prescription) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a doctor.
- The practice participated in a medicines optimisation programme. This involved staff working with medicines management teams to review prescriptions of high-cost items to make sure they were used appropriately. This also identified training opportunities for staff to help optimise the administration of medicines. This included medicines management training for receptionists and administrators, repeat dispensing training for GPs and inhaler technique training for nurses.
- The practice had reduced the prescribing of antibiotics by 4% between 2013 and 2016, which was better than the CCG target of 1%.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available, which staff reviewed annually. The practice had up to date fire risk assessments and carried out regular fire drills. Key members of staff were trained as fire marshals and a named responsible person was in place at all times the practice was open to the public. This individual would be responsible for coordinating an evacuation.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. A named responsible person was in place for water supply and temperature monitoring and audits of tank inspections and legionella records was well established.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Clinical staff worked responsively to the needs of patients and to ensure urgent appointments and home visits were available every day. This meant although more clinical staff were needed to achieve a full team, patient care and safety was not compromised.
- The practice was planning a simulated exercise to assess how staff responded to patients who became unwell whilst in the practice. This would include an evaluation of response times and staff action.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. GP partners had laptops that could act as back-ups if the practice computer system failed, which would minimise disruption to the service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The urgent care practitioner was a member of the College of Paramedics and adhered to national best practice guidance in urgent and emergency care.
- The practice monitored the use of guidelines through risk assessments, audits and random sample checks of patient records. For example, staff used NICE guidelines to monitor the prescribing of medicines for urinary tract infections.
- The practice worked with district nurses to implement the Gold Standards Framework for patients who received palliative care.
- Clinical staff were developing a new protocol to help identify when fractures had been caused by fragility.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results showed the practice had achieved 98% of the total number of points available. The average exception rate was 5% across all 35 QOF indicators, which was significantly better than the clinical commissioning group (CCG) average (11%) and the national average (9%). Exception rates were better than the CCG and national averages in 20 out of 21 clinical domains. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effect. Clinical staff were proactive in improving screening and care for patients with atrial fibrillation. This including teaching sessions delivered by a cardiologist, an audit of known patients with the condition and opportunistic pulse checks by the healthcare assistant and urgent care practitioner.

This practice was not an outlier for any QOF clinical targets. Data from April 2014 to March 2015 showed:

- Performance for diabetes related indicators was better than the national average in three out of five indicators and worse than the national average in two indicators. For example, 100% of patients diagnosed with diabetes had a flu vaccine compared to the national average of 94%. 92% patients had a foot examination and risk classification compared with the national average of 88%.
- Performance for mental health related indicators was better than the national average in all three indicators. This included significantly better performance for patients with schizophrenia, bipolar affective disorder and other psychoses who had an agreed, documented care plan in the previous 12 months (95%) compared with the national average (88%).

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits completed in the last year, all of which were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. This included mortality reviews and audits of two week referrals.
- Findings were used by the practice to improve services. For example, audits of the two week wait referral process highlighted areas that could be more efficient in this process. During the re-audit, an improvement of 3.5% was made towards meeting two week wait targets.
- A review of patient prescriptions had led to a reduction in the waiting times, from seven days to 48 hours in most cases.
- An audit programme for 2016/17 was in place. This included a monthly health and safety audit and 12 other individual audits, including compliance with the disability discrimination act and safeguarding.

Information about patients' outcomes was used to make improvements. For example, doctors identified there was a

Good

Are services effective?

(for example, treatment is effective)

need for improvement in how bone fractures were investigated, particularly in relation to older people and those with fragility. To address this a fragility care protocol was being established.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Specific inductions were in place for trainee doctors and locums. These were fit for purpose and meant new staff were able to work safely within established protocols.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, GPs achieved accreditation to offer dermatology services and the emergency care practitioner received on-going training to be able to provide targeted services and care. The healthcare assistant undertook training that enabled them to provide clinical support to nurses, including national vocational qualifications and the phlebotomist was scheduled to take an advanced phlebotomy course to increase the scope of their service.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. The urgent care practitioner had a mentor and underwent regular clinical supervisions of their work, including their developing skills in ear, nose and throat and abdominal care and assessment. The healthcare assistant and phlebotomist had been assigned mentors when they started their roles and received on-going supervision whenever needed. All staff had received an appraisal within the last 12 months.
- Staff had access to and made use of e-learning training modules and in-house training. The practice had a 95% target for the completion of up to date mandatory refresher training and all staff were provided with protected time for this on a monthly basis. The practice met or exceeded this target for training in basic life support and cardiopulmonary resuscitation, safeguarding adults, safeguarding children, automatic external defibrillation and health and safety. The practice did not meet the target in nine other training areas, including equality and diversity (50%) and fire safety (86%). The practice manager used a workforce strategy to improve training compliance.
- A GP met with the urgent care practitioner on a weekly basis to review a sample of patient notes, particularly those with complex conditions or where a new condition had been found. The meetings were minuted and we saw evidence of continual learning and professional development.
- The surgery was a training practice and accepted fourth year medical students and FY2-grade doctors. Trainee and junior staff received on-going supervision and 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 intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. Staff were proactive in communicating with other medical care professionals to avoid hospital admissions where possible. For example, a GP had obtained guidance from an on-call renal consultant when a patient's renal function caused them concern. This helped the GP to provide treatment that did not require a hospital admission. In addition, clinical

Good

Are services effective?

(for example, treatment is effective)

staff were able to refer patients directly to specialist hospital services where appropriate, which reduced the pressure on accident and emergency by avoiding unnecessary attendances.
- A GP attended hospital mortality reviews of all patient deaths in the practice. This was used to explore the care and treatment the patient received in the time before their death, to make sure the practice met individual needs.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

- Staff within the practice collaborated to ensure their shared skill set met the needs of patients. For example, we saw the phlebotomist and urgent care practitoner work well together to take blood samples from patients whose veins were difficult to access.
- Multidisciplinary meetings took place with other health care professionals on a three monthly basis when care plans were routinely reviewed and updated for patients with complex needs, including palliative care and safeguarding needs.
- Staff demonstrated attention to detail when considering how to engage with other services to promote patient safety and wellbeing. For example, the urgent care practitoner had arranged for the local fire service to visit a patient's home and give them support and guidance in fire safety after they were concerned about this during a home visit.

The practice monitored patients who were at high risk of hospital admission. The practice had identified 138 patients in this group, all of whom had an up to date care plan. GPs followed up patients who were admitted to hospital and escalated concerns appropriately to ensure their needs were met. For example, a GP submitted an incident report to an acute trust when a patient was not admitted from the accident and emergency department in a timely fashion, which negatively impacted their health.

The urgent care practitioner offered follow-up appointments to patients after they experienced an unplanned hospital admission.

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 and could evidence their adherence to the Gillick competencies.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits and staff were proactive in discussing complex cases with multidisciplinary specialists. For example, when a patient with mental health needs stopped taking essential medicine, their GP led a best interests meeting with other appropriate professionals to ensure the patient's safety was maintained.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, and those requiring advice on their diet and smoking cessation were referred and signposted appropriately. A range of signposting contact details were available to local services, including alcohol and drug support and rape crisis services.
- Patients at risk of developing diabetes were offered regular reviews for pre-diabetes.

The practice's uptake for the cervical screening programme was 81%, which was better than the CCG average of 76% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe

Good

Are services effective?

(for example, treatment is effective)

systems, led by a dedicated member of staff, to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 0% to 97% and five year olds from 90% to 99%.

The practice performed better than the CCG average in the uptake of bowel cancer screening and breast cancer screening within six months of invite. 71% of female patients aged between 50 and 70 were screened for breast cancer compared to the CCG average of 67% and 60% of female patients aged between 50 and 70 were screened for breast cancer compared to the CCG average of 54%.

Patients had access to appropriate health assessments and NHS health checks. Practice nurses offered healthy heart checks to patients 40–70. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and 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.
- We observed personal details given by patients at the reception desk could sometimes be heard in the waiting room. However, reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- During our observations reception staff spoke to patients in an appropriate manner and demonstrated clear respect and friendliness. Patients we spoke with also commented on this.

All of the 28 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Patients particularly noted the time clinical staff spent with them in managing chronic conditions and the friendliness of reception staff.

We spoke with two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They highlighted the pressure on clinical staff as a result of the need for more doctors and said they felt the practice still maintained a consistent service. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required, including at home and by phone.

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

- 90% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 85%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 82%.
- 94% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

Good

Are services caring?

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

- Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format and in commonly spoken languages locally.
- Staff provided carers with support and guidance to help them make decisions with the people they cared for.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 150 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them and the practice monitored their health, including offering flu vaccinations and annual checkups.

A counsellor was available in the practice on a part time basis and clinical staff could refer patients to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. A patient told us they had received genuinely caring support and guidance from staff when a relative received a terminal diagnosis.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified.

- Saturday morning appointments were available to help reduce the disruption to patients' work and study time during the week.
- There were longer appointments available for patients with a learning disability, complex conditions or who needed more time to talk.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. This included visits to care homes.
- Same day appointments were available for children and those patients whose needs meant they were unlikely to adhere to scheduled appointments.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had a wheelchair accessible lift and ramp access from the car park.
- Equality and diversity training formed part of the practice's mandatory training programme for all staff. This included guidance for staff on how to provide equitable access to care regardless of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation and people with complex needs.
- Clinical staff offered dementia screening and cognitive testing, which were followed up with patients and specialists appropriately.
- The practice established the needs of patients who were drug users and put support in place for them. This included a dedicated named GP who had undertaken specialist training. A drug support worker was available two days per week in the practice to provide care and support for patients who were prescribed methadone.
- The practice had introduced an urgent care practitioner role. This member of staff was a qualified paramedic and saw patients with specific minor illnesses. This meant there was an increased capacity for GPs to see patients with more complex needs. The member of staff was able to conduct home visits daily, which meant patients who were too unwell to attend the practice could be seen more quickly. This was in addition to urgent home visits available by a GP each day.
- Clinical staff demonstrated an acute understanding of the needs of older patients. For example, they understood that minor health problems could develop because patients did not want to bother staff. To address this, staff engaged with patients to help them with preventative measures to reduce the risk of common conditions such as pneumonia, fractured neck of femur and falls. Staff worked with local social services to ensure patients had social care support and to obtain equipment to help them live independently, such as walking aids.

Access to the service

Appointments were from 8.30am to 6pm Monday to Friday and from 9am to 12.45pm on Saturdays. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them and could be booked online from 6.30pm the day before or by telephone on the day the appointment was needed.

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

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 80% and the national average of 78%.
- 86% of patients said they could get through easily to the practice by phone compared to the CCG average of 68% and the national average of 73%.
- A telephone triage service was available that enabled patients to receive a call-back from a GP within 48 hours.
- The urgent care practitioner provided a rapid response for home visit requests and to review patients who had been readmitted to hospital.
- The practice had a system in place to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Information was given to patients in the practice this included: an information leaflet about how to access appropriate care, including minor injuries units, a minor ailments service and pharmacy services for 24 common conditions.
- The practice cared for patients in local nursing homes and doctors conducted regular visits there to ensure patient needs were met.
- Staff contacted patients who did not attend scheduled appointments. This was to check their level of medical need and to discourage appointments being wasted.
- In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available in the practice and online to help patients understand the complaints system.

We looked at five complaints received between March 2015 and June 2016. In all cases patients received an initial response from the manager that outlined the timeframe in which they could expect a resolution. The practice demonstrated open communication with patients and a commitment to appropriate investigations. Lessons were learnt from individual concerns and complaints and the practice liaised with other agencies where necessary, including NHS England.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a patient's charter which was available in the waiting area that included a number of promises to patients, such as ensuring confidentiality and making the practice a welcoming place. Staff also promoted the 'what to expect from your doctor' guidelines of the General Medical Council, which was freely available to patients.
- The practice had an effective strategy and supporting business plans which reflected the vision and values and were regularly monitored. The new practice manager had recently reviewed these to ensure they continued to meet the needs of the practice, its patients and staff.
- The practice needed one additional GP and one additional practice nurse to be able to fully meet the needs of all registered patients within staff contractual hours. A recruitment campaign was active and in the interim staff were working extended hours and with staggered annual leave to reduce the impact on patients but this was not sustainable on a long-term basis.
- The practice was participating in a 'blueprint' exercise with 54 other GP practices in the local area to identify ways of streamlining and combining services between practices. Learning from this exercise would be used to plan clinical staffing more efficiently to address on-going GP shortages in the local area.
- Long-term sustainability was a focal point of the senior team and formed part of the service's strategy alongside recruitment of more clinical staff. The practice team included the avoidance of unnecessary attendances at accident and emergency as part of the sustainability plan. To achieve this, GPs and the urgent care practitioner were able to refer patients directly onto multidisciplinary care pathways at local hospitals.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained through staff self-reflection, supervision and peer reviews.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. Staff reviewed this through six weekly clinical meetings and monthly practice meetings.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This took place through monthly partner meetings, which were used to identify areas of clinical need but were not formally structured as clinical governance meetings. There was room for improvement in the involvement of practice nurses in clinical meetings and governance structures. For example, nurses attended patient tracking list meetings but did not routinely attend other clinical meetings, including with practice nurse forums in the locality or in palliative care multidisciplinary meetings. The senior team recognised this resulted from short staffing and the need for nurses to work extended clinical hours. To address it, a new clinical governance structure was planned that would include all staff in a weekly meeting to include clinical issues and significant events.
- Information governance training was provided to all staff and a new 'clear desk' policy had been introduced to ensure staff maintained patient confidentiality and data protection at all times.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They demonstrated how they prioritised safe, high quality and compassionate care. Staff told us the senior team were approachable and always took the time to listen. Staff at every level of the practice said they felt valued. A monthly meeting took place with all practice staff, which we were told was a positive opportunity for people to learn from each other.

A new practice manager had been appointed who had prioritised staff support and development. For example, they had conducted one-to-one meetings with each

Are services well-led?

Good

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

member of staff to establish their ambitions and development needs. The practice had also experienced changes in the GP team. All of the staff we spoke with said they had felt supported during the changes and that the senior team had made sure everyone had what they needed to do a good job.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty, which staff spoke positively about. Most staff knew who the lead was for incidents but two clinical staff said they did not know who it was. The practice had systems in place to ensure that when things went wrong with care and treatment::

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

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

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners 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 encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaint investigations. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had helped to design and implement a refurbishment of the waiting room to make it more welcoming and comfortable. In addition, members helped to design a change of the practice logo to make it less religiously-affiliated. Members of the PPG were also invited to take part in staff recruitment interviews to help establish their ability to meet the needs of the local population.
- Members of the PPG were aware the group was not fully representative of the practice population and tried to engage with more patients to encourage them to participate.
- The new practice manager had conducted a staff survey that found staff were positive above working there and would recommend the practice to family and friends. It also highlighted the need for more robust line management in some areas, which was implemented. The survey also identified the need for a more structured approach to staff meetings, which replaced the previous approach of an open forum.
- Trainee doctors were asked to complete feedback forms on their placement in the practice. The most recent six forms were all positive about their supervision and experience and indicated they would benefit from an increased number of weekly clinics.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice participated in a pilot scheme from the CCG for an electronic virtual receptionist service that would reduce delays in reaching the practice by phone during staffed hours and would provide more rapid and convenient access to repeat prescriptions. The practice planned to use the results of the pilot to consider the benefits for its patients in the future, if the CCG adopted the virtual service.

A new clinical and safety audit plan was due to be implemented in July 2016. This would include a significant element of peer review amongst clinical staff to establish areas of good practice and where there was room for improvement.

Are services well-led?

Good

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

The senior team and urgent care practitioner worked together to build the profile and scope of this role. This included plans to complete an independent prescribers course and a Masters qualification.