

# Woodside Health Centre

## Quality Report

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

## Ratings

### Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8
Areas for improvement	8

### Detailed findings from this inspection

Our inspection team	10
Background to Woodside Health Centre	10
Why we carried out this inspection	10
How we carried out this inspection	10
Detailed findings	12

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Woodside Health Centre on 9 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for 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 and people experiencing poor mental health (including those with dementia).

Our key findings were as follows:

- The practice team were aware of the health needs and challenges of the local population and were responsive in providing services to meet those needs and challenges.
- Access to appointments and continuity of care were positive features.
- The practice was and clean and well equipped.

- 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.
- Most patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

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

The provider should:

- Review the emergency medicines held for the treatment of seizures to ensure that they are age appropriate.
- Improve methods of communication with both local residential care settings and the community matron to promote partnership working to benefit care and treatment to patients.
- Improve learning and reflection from complaints to reduce the trend in complaints received at the practice where patients feel they have been spoken to with uncomfortable challenge.

# Summary of findings

- Explore the reasons for, and respond to, negative feedback via NHS choices.
- Share learning from complaints and significant events with all staff to promote a learning culture through all levels of staff.

**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?

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Risks to patients were discussed with the staff involved and when necessary changes had been made to limit the risk. We saw that risks to patients, staff and visitors from the premises or environmental events were clearly recorded. Practice staff had been trained to deal with emergency events. Equipment and medication to help in an emergency was regularly checked and suitable for use.

Good



### Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) 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 some multidisciplinary teams.

Good



### Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with others for most aspects of care. The data sources we reviewed showed that satisfaction levels with interactions with GPs were broadly lower than local and national averages. For example, In the GP national patient survey published in January 2015, 67% of patients said the last GP they saw was good at involving them in decisions about their care compared to the clinical commissioning group average of 79% and national average of 81%.

Patients we spoke with on the day of our inspection said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



# Summary of findings

## Are services responsive to people's needs?

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

Patients told us it was easy to be seen urgently and that continuity of care were both positive features of the practice. 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. We saw that complaints were responded to quickly, however learning from complaints was not shared with staff and at times it was not clear how learning from complaints was used to minimise the chance of them happening again.

Good



## Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify most risks. We saw that the practice had performed strongly in areas such as safe and effective prescribing within the local clinical commissioning group (CCG) area.

Good



# 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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and avoiding unplanned admissions to hospital. It was responsive to the needs of older people and offered rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP.

Good



### People with long term conditions

The practice is rated as good for the care of people with long-term conditions. The practice nurses had a lead role 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 that their health and medication needs were being met. For example, 93.3% of patients with chronic obstructive pulmonary disease (COPD) had received a health review in the last year. This was higher than the CCG average of 82.2% and national average of 80.4%.

Good



### Families, children and young people

The practice had a higher than average number of patients of a younger age. We saw that 28.6% of patients were under 18 years of age. This is significantly higher than the clinical commissioning group (CCG) average for GP practices of 16% and national average of 14.7%.

The practice immunisation rates to help protect against childhood illness were higher than both local and national averages. Staff had appropriate training in safeguarding children and had systems in place to highlight children who may have been at increased risk of harm. A GP met regularly with a health visitor to discuss the needs of children registered at the practice. The practice provided a full range of contraceptive and sexual health services on site. This included bookable 20 minute appointments with GPs and a nurse to provide sexual transmitted infection clinics that included undertaking all necessary tests within the practice to provide a full assessment and screening in one visit. Counselling and follow up was routinely provided as part of this service.

Good



# Summary of findings

## **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.

## **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.

Services provided at the practice included access to substance and alcohol addiction counsellors and opiate substitution support by GPs and substance misuse workers delivering care in partnership. The practice demonstrated a solid awareness of patients who may face barriers to receiving care. For example, patients whose first language was not English were supported by extended appointments and the provision of interpreter services.

## **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). Eighty-seven per cent of patients on the practice register who experienced poor mental had received an annual physical health check. The practice had an in house clinical psychologist providing higher level support to patients who required it. The clinical psychologist had worked within the practice for a number of years and was providing around 100 patient contacts each month.

Practice levels of prescribing hypnotic medicines that have a history of being addictive and antidepressant prescribing were among the lowest in the clinical commissioning group (CCG) area. Patients who had a history or an increased risk of taking an overdose of medicines were issued with medicines on a weekly instead of monthly basis to try and reduce the risk of overdose.

# Summary of findings

## What people who use the service say

We spoke with 15 patients on the day of our inspection. The majority of patients felt that staff were caring and compassionate. We heard examples of occasions when patients felt that the GPs and wider practice team had been caring and when patients felt listened to.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 19 completed cards. Most of the cards contained positive comments about the practice and staff. Seventeen contained comments that expressed care was excellent or very good. Two patients expressed that they felt a GP had been rude to them on occasion. We saw cards that contained comments that included the words pleasant, attentive, excellent and caring when describing practice staff.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP national patient survey published in January 2015. The survey was undertaken in January to March 2014 and July to September 2014 and was based on 448 surveys being sent to patients at the practice, of which 122 were returned.

Key findings from the survey data showed;

Patient satisfaction with interactions with GPs was lower than local and national averages. For example;

- 73.5% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86.5% and national average of 88.6%.
- 75.1% said the GP gave them enough time compared to the CCG average of 85% and national average of 86.8%.

Patient satisfaction with interactions with practice nurses was higher than local and national averages. For example;

- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national averages of 90%.

Patient satisfaction with access to the practice was higher than local and national averages. For example;

- 79% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 76% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.
- 87% were able to get an appointment the last time they tried compared with the CCG average of 84% and national average of 85%.

We spoke with the care manager of a local care home. They told us that they had confidence in the practice GPs although they felt communication between the care home and practice could be better. We also spoke with a community matron who provided community based support to patients who have complex health needs, many of which were situated in the care home. They told us that they had tried to implement an effective method of two way communication between them and the practice such as attending multi-disciplinary team (MDT) meetings, although that had not yet happened.

## Areas for improvement

### Action the service SHOULD take to improve

- Review the emergency medicines held for the treatment of seizures to ensure that they are age appropriate.
- Improve methods of communication with both local residential care settings and the community matron to promote partnership working to benefit care and treatment to patients.



## Summary of findings

- Improve learning and reflection from complaints to minimise the trend in complaints received at the practice where patients feel that they have been spoken to with uncomfortable challenge.
- Explore the reasons for, and respond to, negative feedback via NHS choices.
- Share learning from complaints and significant events with all staff to promote a learning culture through all levels of staff.

# Woodside Health Centre

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

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

## Background to Woodside Health Centre

Woodside Health Centre is a purpose built GP practice in the Woodside area of Telford, Shropshire.

The local area is classed as more deprived when compared with both local and national. Unemployment within patients at the practice is over twice the local and national averages. The number of practice patients who report caring responsibility, long-standing health conditions and health-related problems in daily life are all higher than local and national averages. These factors can greatly increase the demand of services on a GP practice.

There are currently around 6,700 patients of all ages registered at the practice. The practice has more patients aged 18 and under than average. Presently 28.6% of patients are under 18 years of age. This is significantly higher than the clinical commissioning group (CCG) average of 16% and national average of 14.7%. Conversely, the rate of older patients is lower than average. We saw that 13% of patients are aged 65 years and over. This is lower than the CCG average of 15.9% and national average of 16.9%.

The practice clinical team comprises four GP partners (three male and one female), a male regular locum GP provides support when required. The all-female nursing team consists of one registered nurse and a healthcare assistant. An additional practice nurse has been recruited and is due to commence employment in early August 2015. The wider practice team of two cleaners and seven administrative staff are managed by a practice manager. A clinical psychologist is based at the practice for eight hours per week. The counsellor is employed by a local mental health trust, although this has been a long standing arrangement and is in response to the increased needs of the local patient demographic.

The practice is open from 8:30am to 6:00pm on Monday to Friday. During these times the reception desk and is staffed and open. Telephone calls are accepted from 8am. The practice offer extended appointments one evening each week until 8:30pm, the day on which evening appointments are held changes to allow access for patients who have commitments on certain evenings.

A number of other services are provided within the practice. For example, consultant paediatrician (child health) and dermatology (skin) clinics, substance and alcohol misuse counselling, minor surgery, practice led sexual health clinics and a full range of contraceptive services.

The practice holds a General Medical Services (GMS) with NHS England and has expanded the services it provides to include a number of enhanced services. Enhanced Services are services which require an enhanced level of service provision above what is required under core GMS contracts.

The practice has opted out of providing out-of-hours cover for their patients. The practice out-of-hours service is provided by The Shropshire Doctors' Co-Operative Limited

# Detailed findings

(Shropdoc). Patients are directed to call Shropdoc directly with urgent health needs out-of-hours, or may have the details of their health needs transferred to Shropdoc following a telephone assessment if they called NHS 111.

## 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

## How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS Telford and Wrekin Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 9 July 2015.

During our visit we spoke with a range of staff including three GPs, a practice manager, a healthcare assistant and two members of administrative staff. We also spoke with 15 patients who used the service.

The Care Quality Commission (CQC) lead inspector spoke with the practice nurse before the visit by telephone, as they were not available on the day of inspection. The CQC lead inspector also spoke with the manager of a local care home, a community matron and a clinical psychologist based at the practice. This was to help understand how care and treatment provided at the practice was provided in the wider community and population groups.

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 spoke with two members of the practice patient participation group (PPG), 15 patients and received 19 Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

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)

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. A GP told us the practice team had discussed significant events at practice meetings for a number of years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these.

Serious events were raised by completion of a standard form available on practice computers which was completed and submitted to the practice manager. The practice had recorded eight significant events in the last year. We tracked three incidents and saw that investigation, discussion and action had taken place in a comprehensive and timely manner in all of them. We saw that significant events were recorded for occurrences that would be seen to be positive. For example, one significant event detailed the treatment of a patient who presented with symptoms that could have been suggestive of cancer. The treating GP had arranged urgent investigations which had resulted in an early diagnosis of cancer. The early diagnosis had led to a better outcome for the patient. A GP told us discussing events in this way helped to share learning and improve outcomes for patients.

All significant events were discussed within weekly clinical meetings. The meetings included the GPs and practice manager; however other staff were involved when relevant to their area of practise.

National patient safety alerts were shared by the GP who received them. Staff we spoke with were able to give

examples of recent alerts. They also confirmed alerts were discussed within the practice to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding to an appropriate level. For example, the GPs had received training to level three as suggested in guidance by the Royal College of Paediatrics and Child Health on safeguarding children and young people (March 2014).

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

The practice had an appointed lead GP for safeguarding and the staff we spoke with knew who the safeguarding lead was and how to raise concern. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged. For example, the practice had 75 children recorded as being involved in "Team Around the Child" (TAC). TAC is a framework in which parents and practitioners work together to support children who have been identified as having additional needs. A GP told us about their individual responsibility in ensuring that children were protected from harm. The practice team met with the local health visitor on a monthly basis to share information and would contact them sooner if required.

The practice had a policy on providing chaperones and displayed the availability of chaperones on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). It was usual practise for practice nurses to act as a chaperone, although other staff were trained and had performed the duty. All staff had received the necessary background checks to ensure that they could perform the role in a safe and effective manner.

# Are services safe?

## Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept within the required temperatures which described the action to take in the event of a potential failure. We saw records to confirm staff members undertook daily checks of the medicines.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurse administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and evidence that they had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept secure at all times and were handled in accordance with national guidance.

## Cleanliness and infection control

We observed the premises to appear clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control and had received updates specific to their role. We reviewed records of the most recent practice audit which had been performed in 2015.

The practice had completed a risk assessment for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). A member of practice staff had undertaken training to enable them to check the temperature of water outlets in the practice as part of the risk assessment. We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

## Equipment

Staff we spoke with told us they had suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the date of the last test. We saw that equipment used in the assessment of a patient's condition had been checked and calibrated where necessary to ensure it gave accurate readings. For example, a set of weighing scales.

## Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment in all but one case. For example, proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS) where required.

The practice manager told us about arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. This was based on experience of increasing the number of staff on duty when the practice was busy. For example, an additional member of administrative staff was on duty at practice opening times as the practice was at its busiest then.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

## Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice manager told us that they undertook regular checks of the building and discussed risks with staff proactively. We saw that the practice recorded the activities associated with risks. For example, monthly premises checks were documented.

The staff we spoke with were able to describe the actions they would take if they were faced with an emergency situation, for example a patient whose health deteriorated suddenly. Practice staff gave us examples of situations they had appropriately dealt with.

## Are services safe?

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support.

Emergency equipment was available at a secure central point. Equipment included a nebuliser (a device to help to deliver medicine into the lungs to assist someone with difficulty in breathing), a pulse oximeter (to measure the level of oxygen in a patient's bloodstream) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm).

Emergency medicines were available in a lockable carry box within a secure central area of the practice. A range of medicines were available to deal with medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a person experiences

a seizure/fit) and hypoglycaemia (a very low blood sugar level). We saw that the medicine to treat seizures was in a strength that made it suitable for administration to anyone over the age of six years of age. A patient younger than this would not be able to receive the medicine if it was needed as it would be too strong. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms. Guidelines were discussed within protected learning time, in peer discussion and at clinical meetings when appropriate.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The practice delivered a range of enhanced services (ES) to provide patients with additional care and treatment at the practice. ES are the provision of services beyond the contractual requirement of the practice. An example was the avoiding unplanned admission (AUA) enhanced service. The practice had identified over 2.5% of patients who were at high risk of emergency admission to hospital. The amount of patients identified was higher than the 2% that is required as part of the ES. Patients on the AUA register had individualised care plans which were regularly reviewed and changed to meet patients' care and treatment needs. In the event that a patient on the AUA was admitted to hospital, on discharge a GP would contact them to review their care needs. The practice team met on a monthly basis to discuss patients on the admission avoidance plan. Other ES offered at the practice included minor surgery, and extended opening hours.

Patients who experienced poor mental health had access to an in house clinical psychologist. The clinical psychologist worked at the practice for eight hours on a weekly basis. We spoke with the clinical psychologist who was employed the healthcare NHS foundation trust that provided mental health services in the area. They told us

that they had worked at the practice for a number of years and that the service had been implemented due to the high level of support that was required by some patients. Most patients that received the service were female. We heard that group work took place regularly including support groups for sexual health and domestic abuse. The clinical psychologist told us that the service was designed to fit around patients. This included no limit on the period of interaction; some patients had been accessing the service for years. They also told us that the GPs were always accessible and in touch with the needs of their patient population. Around 100 patient contacts were made on a monthly basis with urgent referrals being seen with two weeks and routine referrals within three months.

Two GPs had received further training and were able to manage the community administration for opiate substitution medicines. The practice worked with a member of the local substance misuse team to monitor the progress of patients who wished to engage in the program to replace addictive drugs such as heroin with prescription medicines to control and reduce dependency over time.

The practice provided an in house sexually transmitted infection clinic for patients. This service used an extended trained GP and a nurse to assess, counsel and provide all necessary blood and microbiological sample taking in an extended appointment. Patients could choose a male or female GP and appointments were released on a weekly basis. A GP told us that providing the service as a "one stop shop" resulted in patients being able to access services closer to their home.

### Management, monitoring and improving outcomes for people

The practice showed us three completed clinical audits that had been undertaken in the last two years. All of the audits had been completed then revisited and changes that resulted since the initial audit were demonstrated. For example, following an alert received at the practice concerning a change in guidance when prescribing a medicine used to relieve the symptoms of nausea, the practice audited the number of patients that may need a medicines assessment. Thirteen patients were identified and were subsequently contacted and had their medicines reviewed. Following a re-audit two months later it was

# Are services effective?

## (for example, treatment is effective)

discovered that all patients were receiving medicines as appropriate following the change in guidance. Other audits included the level of improvement in symptoms after injections and inhaler use.

We saw that staff discussed the practice performance in the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice had achieved 99.5% of the total QOF points available to them in 2013/14; this was higher than the national average of 94%. A GP told us that they expected the 2014/15 results to be 100%. We also saw numerous examples of practice performance that was higher than the local and national average. For example:

- 97.3% of patients with dementia had been reviewed in the last year. This was significantly higher than the clinical commissioning group (CCG) average of 74.7% and national average of 77.9%.
- 86.3% of patients with hypertension (high blood pressure) had a recent recorded blood pressure reading lower than the highest acceptable limit. This was higher than the CCG average of 79.3% and national average of 79.2%.
- 93.3% of patients with chronic obstructive pulmonary disease (COPD) had been reviewed in the last year. This was higher than the CCG average of 82.2% and national average of 80.4%.

The practice had implemented a process of repeat prescribing that had increased the monitoring of medicines being taken by patients and had resulted in the reduced need for patients to attend or contact the practice to request repeat medicines. A GP told us that patients who took certain repeat medicines could choose to receive a 12 month issue via a local pharmacy. The issue of the medicines was done on a monthly basis by a pharmacist without the need for a patient to request a repeat prescription via the practice. The GP told us that the pharmacy would contact the practice if a patient was not collecting their medicines regularly which gave the GP increased oversight over a patient's compliance with taking medicines. Practice records showed that 1,956 out of 3,659 patients received medicines in this way. We also saw that patients' medicine and condition reviews were booked into 2016; the GP we spoke with told us that medicines would

not be dispensed unless the patient had attended a condition and medicines review. Repeat prescribing in patients whose circumstances who may make them vulnerable was limited to one weeks' supply. A GP told us that this was to minimise risks, one example was patients who had a history of taking an overdose of medicines.

GPs told us they used nationally recognised methods of the fast track referral to hospital specialists for patients who had symptoms that could be suggestive of cancer. We reviewed data from Public Health England from 2014 which showed the rates for using nationally accepted standards for patients with such symptoms were in line with both the local and national average.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a wide range of experience and good skill mix amongst the GPs with some holding additional diplomas or training in medically related areas. One example was two GPs had undertaken further training to provide sexual health services. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a healthcare assistant was completing a level three qualification and confirmed that they had received support from the practice to undertake and complete the qualification.

### Working with colleagues and other services

The practice had an established system in place for handling and taking action on the information received from local hospitals, out-of-hours providers and the 111 service. The information received was both in an electronic and paper format. Communications included blood test results, hospital discharge summaries and letters from other health partners about the care and treatment of



# Are services effective?

## (for example, treatment is effective)

patients. We spoke with staff who were able to describe and demonstrate the system in place for managing communications. The system involved tasking of actions to individual members of staff and where appropriate patients were contacted with an appointment date to discuss results with a GP. The staff we spoke with felt the system worked well. We checked and saw that the management of communications was up to date. There had been no recorded incidents during the previous year where any communication item had not been followed up.

Meetings to discuss the needs of patients who were approaching the end of their life were held on a monthly basis. The meetings were attended by specialist palliative care nurses, GPs and others relevant to meeting the care needs of patients. We reviewed minutes of meetings that showed clear actions and interventions had been taken in response to the sharing of information.

### Information sharing

The practice used computer systems to communicate with other care providers. One example was a shared computer system with the local GP out-of-hours provider that enabled relevant patient data to be shared and accessed in a timely way.

Within the practice, staff used systems to coordinate, document and manage patients' care. This involved tasking duties to individual members of staff. The staff we spoke with were aware of their own role in ensuring information was shared and was acted upon appropriately.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in decisions about the care they received. An example of this was that 86.5% of patients on the practice register for experiencing poor mental health had received an annual health check. A GP described an example of when a patient's capacity had been reassessed and their care plan adjusted to suit their changing needs.

A GP told us that patients and those close to them were supported through decisions when their capacity may be impaired. For example, patients approaching the end of

their life received guidance on recording their treatment wishes in the event of their health deteriorating. This information was recorded in patient notes and templates to nationally recognised standards.

Patients' consent to minor surgical procedures was recorded on a standard template. The template was a written record of the benefits, risks, complications and patient's agreement to receive the procedure. The completed consent template was scanned into patients' notes.

### Health promotion and prevention

The practice offered a range of in house health promotion services in conjunction with the CCG. These included NHS health checks, smoking cessation, weight management and childhood immunisations.

It was practice policy to offer all new patients a health check when joining the practice. The practice waiting room contained posters and leaflets on health promotion subjects and provided patients with contacts for other organisations that may have been able to support with living a healthier lifestyle

We saw that the most recent published QOF data from 2013/14 showed that vaccination rates for standard childhood immunisations were higher than the local average. For example, 98% of children aged one had received the pneumococcal vaccine (PCV) to help reduce the risk of acquiring the bacteria that can cause pneumonia, blood poisoning and meningitis. This was higher than the CCG average of 96.5%.

The practice rate for cervical cytology screening for female patients aged 25 to 64 years at the practice was 76.6%, this was slightly lower than the CCG average of 77.3%. The practice nurse followed up patients who did not attend screening appointments, which involved multiple reminders if necessary.

National data published by Public Health England in 2014 showed the rates of practice patients attending, or participating in, screening to detect signs that may be suggestive of cancer were mainly slightly lower than CCG average. For example, 51% of patients in the age range of 60 to 69 had participated in bowel screening in the last 30 months. This was slightly lower than the CCG average of 57.4% and national average of 58.3%.

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP national patient survey published in January 2015. The survey was undertaken in January to March 2014 and July to September 2014 and was based on 448 surveys being sent to patients at the practice, of which 122 were returned.

The evidence from the GP national patient survey showed patients satisfaction levels with how they were treated during interactions with GPs were mostly lower than local and national averages. For example;

- 73.5% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86.5% and national average of 88.6%.
- 75.1% said the GP gave them enough time compared to the CCG average of 85% and national average of 86.8%.

We spoke with 15 patients on the day of our inspection. The majority of patients felt that staff were caring and compassionate. We heard examples of occasions when patients felt that the GPs and wider practice team had been caring and when patients felt listened to.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received 19 completed cards. Most of the cards contained positive comments about the practice and staff. Seventeen contained comments that expressed care was excellent or very good. Two patients expressed that they felt a GP had been rude to them on occasion. We saw cards contained comments that used words that included pleasant, attentive, excellent and caring in the cards received.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A system operated to allow only one patient at a time to approach the reception desk. Data from the GP national patient survey showed that 83.3% said they found the receptionists at the practice helpful compared to the CCG average of 85.5% and national average of 86.9%. Three patients we spoke with told us that they were not satisfied with a system for getting attention when the reception desk

was not staffed. They told us that at times the reception desk was not staffed and it could take some time for a member of staff to attend to them after ringing a bell. The practice manager was aware of patient concerns in this area and had produced an action plan to identify if staff required any additional training to perform reception duties also if staffing levels were sufficient to provide the level of cover on reception required.

### Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded with mixed opinions to questions about their involvement in planning and making decisions about their care and treatment and rated the practice mainly below others in these areas. For example:

- 76% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 67% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 81%.

Most patients we spoke with felt involved in decisions relating to their care and treatment. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff were aware of patients that needed additional support to understand any decisions that may need to be taken in relation to their care and treatment. They told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

### Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients responded positively to questions about involvement in planning and making decisions about their care and treatment and rated the practice in line with others in these areas. For example:

- 64% with a preferred GP usually get to see or speak to that GP compared to the CCG average of 59% and national average of 60%.

## Are services caring?

- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national averages of 90%.
- 69% would recommend the practice to someone new to the area compared with the CCG average of 73% and national average of 78%.

We received numerous positive comments from patients we spoke with and within comment cards about the emotional support provided by staff at the practice. We heard examples of occasions of when patients felt that they had received high levels of support at difficult times.

Staff told us that if families had experienced a bereavement, their usual GP contacted them. 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. Patients we spoke with who had experienced a bereavement confirmed they had received this type of support and said they had found it helpful.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice team showed a solid understanding of the health needs of their patients and we saw numerous examples of how services provided had been shaped to meet patients' needs. The practice worked with local health partners to provide services close to home for patients. For example, a twice monthly outpatient clinic for babies and children was held within the practice led by a consultant paediatrician. A GP told us this was a result of discussions between all health agencies following did not attend appointment rates for hospital outpatient clinics for children being previously high. The local hospital was situated around eight miles away and for those with no transport could only be accessed by catching two buses.

In house services provided included spirometry (lung function testing), blood sample taking and electrocardiogram (heart rhythm assessment). A number of specialist clinics were also held at the practice by hospital consultants. For example, dermatology (skin) and ophthalmology (eye) clinics.

The practice identified patients who may require additional time with a GP. For example, patients whose first language was not English had a double appointment to allow for the additional time to speak and communicate with an interpreter. Another example was patients who used wheelchairs had a computer record alert to inform the GP to change rooms to a more accessible consultation room.

Patients who had alcohol or other substance misuse issues were supported on site by GPs with additional training in opiate substitution and specialist drugs and alcohol counsellors attended the practice on a weekly basis to provide higher level emotional and behavioural support to patients who wished to seek help.

Home visits were available when required; we spoke with patients who told us that they had been able to request a home visit from a GP when needed.

We found examples of areas where communication was not as good as it could be. Before our inspection we contacted a local community matron. They told us that they did not attend multi-disciplinary team (MDT) meetings as they had not been invited. We also spoke with a senior member of staff from a local care home, where 45 patients registered at the practice lived. They were unaware of the

avoiding unplanned admissions enhanced service and were not aware if any of the residents were part of this service. Due to the complex and often multiple medical conditions of the residents it would be reasonable to assume that patients who lived at the care home would be part of this service. We spoke with a GP about these issues. They told us that a meeting was planned for the coming weeks to explore improving communication with both the community matron and local care home. They also confirmed that patients in the care home had not been included in the unplanned admission enhanced service as there had been misunderstanding about its function between the two parties. The GP we spoke with said that the patients who lived in the care home would be suitable to be included in the enhanced service and they would and had offered to provide the associated care package.

We spoke with two members of the practice participation group (PPG). PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services. Both told us that the standard of care provided at the practice was of a good standard. Meetings with the PPG had not been held for a number of months. The practice manager who had been employed for five weeks before the date of our inspection had produced an action plan to improve the communication with the PPG. This included new advertisement within the practice waiting area and opportunistic promotion of the PPG by practice staff. The action plan also contained timescales for meetings and the implementation of practice led surveys to get a wider view of patients' opinions of the services provided.

The practice offered extended opening hours until 8:30pm one evening each week and offered bookable telephone consultations which benefited those of a working age.

### Tackling inequity and promoting equality

All facilities at the practice were situated on a single level and all accessed by automatic opening doors. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. Examination couches were automatic and adjustable height and waiting room chairs had armrests to assist patients who had difficulty in standing from a sitting position.

The practice manager told us about the assistance they had provided to patients whose first language was not

# Are services responsive to people's needs?

## (for example, to feedback?)

English. For example, a family claiming asylum had recently registered at the practice. The practice had communicated with the family's key worker and sourced an interpreter. All members of the family had attended for double length appointments for new patient health checks and all of the children had been seen within the same clinic session in succession. Alerts were placed on patients' records who needed additional support, for example those who used wheelchairs. On receipt of the alert, one GP told us they knew that they needed to change clinic rooms as it could be difficult to access their clinical room in a wheelchair.

The practice was not aware of any patients that had circumstances that could present challenges to meeting the requirements of registering for GP services. For example, a person who was homeless. The practice manager told us that individual circumstances were taken into account when registering at the practice.

All of the staff at the practice had completed equality and diversity training. The practice staff we spoke with were all able to demonstrate they recognised the importance of treating all patients, carers and visitors with equality and respect for diversity.

### Access to the service

The practice was open from 8:30am to 6:00pm on Monday to Friday. During these times the reception desk and telephone lines were always staffed. Telephone calls were accepted from 8am, although the reception desk was not open until 8:30am. The practice opened one evening each week until 8:30pm, the day changed to allow access for patients who had commitments on certain evenings. Appointment times varied during different times throughout the day and had reflected the availability of the GPs. Patients could book appointments in person, by telephone and by using an online system for those had registered to access appointments in this way.

Urgent health needs could be met by patients attending a morning or afternoon dedicated urgent clinic session. The practice manager told us that all patients who attended would be seen. We saw that there were urgent appointments available on the day of our inspection and also pre-bookable appointments within a few working days. Telephone consultations were also available for those who requested them.

The GP national patient survey information we reviewed showed a positive response from patients to questions about access to appointments and rated the practice higher than others in these areas. For example:

- 79% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 76% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.
- 87% were able to get an appointment the last time they tried compared with the CCG average of 84% and national average of 85%.

Patients we spoke with were positive about access to the practice. All were satisfied about access to the practice for urgent health needs. We spoke with patients that had been seen both urgently and for routine appointments. A small number of patients commented that appointments could at times overrun, although they were satisfied with access overall.

### 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. The practice displayed clear information on how to raise a complaint in the waiting room and in other practice material. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had received seven written complaints in the previous year. We tracked the complaints and saw that all complaints had been responded to in an appropriate timescale. Those who complained were made aware that they could raise their concerns with the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied following the practice findings after a complaint. We noted a trend in six complaints that patients felt that they had been spoken to abruptly or had their

## Are services responsive to people's needs? (for example, to feedback?)

concerned dismissed. Apologies had been offered, although we did not see that decisive action had been taken or any evidence of reflection to minimise the likelihood of the complaints being repeated.

The practice did have an action plan in place to take acting on complaints forward The plan included regular

discussions with the PPG and the introduction of a large scale patient satisfaction survey. The practice had performed a small survey in 2014; however the results could not be relied on to be the opinions of the wider patient population as the sample size was less than 0.01% of the practice population



# 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 vision statement that included “To provide quality medical services to NHS patients registered with the Practice and to take the opportunity to provide other services, which will be both financially well remunerated as well as professionally rewarding to the individuals involved. The Practice envisages an environment in which all staff have the opportunity to develop.” They planned to do this by applying values that included –

- The Practice wants to treat all its customers as individuals so they feel valued and their needs have been addressed.
- The Practice wants its customers to perceive it as caring and responsive.
- The Practice wishes to be perceived by the local community as providing the best primary health care in the district.

The practice vision and values were displayed on the staff room notice board and staff we spoke with were able to describe the essence of the practice vision and values.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to each member of staff via computer desktop and in the practice manager's office. The practice manager had been in position for five weeks and was in the process of updating and ensuring all policies were up to date.

We saw that clinical governance was tightly controlled. For example, in 22 medicine prescribing outcomes that measured clinical effectiveness, medicines that could become addictive and cost analysis the practice was in the top three performances in the clinical commissioning group (CCG) area for 17 out of the 22 indicators.

The GPs took overall ownership of performance in the Quality and Outcomes Framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice QOF performance for clinical results had been 100% in all

years since 2006. The practice had achieved 99.5% of the total QOF points available to them in 2013/14 and the performance in 2014/15 was 100%, although this had not yet been published.

Weekly clinical meetings were held to discuss governance issues such as significant events, performance and other areas of risks.

### Leadership, openness and transparency

The GP partnership had remained stable for a number of years. The practice manager had recently been employed and had been in post for five weeks at the time of our inspection. The practice manager told us about their plans to take charge of improving the experience of patients by discovering what they felt about the practice.

The staff we spoke with told us that they felt well supported and encouraged to develop.

The practice leadership team were in touch with the health needs of the local population and engaged with numerous other healthcare partners such as local hospitals, mental health teams and the local authority to provide additional services within the practice.

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

The practice had an action plan in place to improve the way that it uses feedback from patients. The patient participation group (PPG) had not met for some months. The practice manager told us that they had advertised for new members and previous members had or were to be contacted to establish their interest for getting the PPG re-established. The practice action plan included using the PPG to survey patients to establish their views on how services at the practice could be improved. Results from the most recent GP national survey published in January 2015 showed a trend in patient interactions with GPs that were around 10% lower than local and national averages. The practice had also received poor feedback on the NHS choices website. The results from these two sources showed a trend that at times, patients felt they had not been treated with the level of compassion they expected. Our findings from speaking with patients and reviewing comment cards were not consistent with the survey or NHS choices website results. Following discussion during the inspection, the practice team had recognised the

# Are services well-led?

Good 

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

importance of learning why the NHS choices results and feedback was lower than expected. The action plan detailed steps to be taken to understand and improve feedback in these areas.

Staff told us that feedback was taken on board where possible and gave us examples of when they had suggested changes to improve services or working practice that had been implemented.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and shared with staff at clinical meetings. The whole practice team met at least twice each year. The practice manager told us they planned to increase the number of whole staff member meetings and also introduce specialist and specific sub groups to concentrate on specific areas of service provision. Non clinical staff we spoke with told us that any significant events or complaints that involved them were discussed on a personal level.