Somerset Family Health Practice

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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Somerset Family Health Practice on 5 July 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- 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 could get an appointment when they needed one with urgent appointments available the same day. However patients told us getting through by telephone was difficult and the practice had identified this as requiring further action. The practice scored below average on the national GP patient survey for access.
- 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 patients, which it acted on.

The areas where the provider should make improvement are:

- The practice should ensure that all staff members are clear about the duty of candour and their responsibilities. The practice should have a written policy and procedure for reference.

Summary of findings

- The practice should carry out an annual audit of infection control in the practice to ensure that it is meeting current infection control guidelines.
- The practice should investigate areas where its performance was unusual, for example in some of its exception reporting.
- The practice should aim to increase the uptake for cancer screening programmes among eligible patients.
- The practice should continue to work to improve patient experience of booking an appointment and the ease of getting through to the practice by telephone.
- The principal GP should ensure that all staff have a structured annual appraisal and are given sufficient support to complete agreed personal development goals.

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.
- Some staff were unclear about the duty of candour but told us that the practice was open and transparent with patients and we saw evidence of this.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Most risks to patients were assessed and well managed. The practice had procedures in place to protect patients and staff from the risk of infection but had not carried out a recent audit.

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 tended to be at or above average.
- Practice exception reporting rates for some indicators including diabetes and cervical screening, were high compared to other practices in the area.
- 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 positively. The practice's results were comparable to the national average.

Summary of findings

- Patients said they were treated kindly and with respect. Patients reported being involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- The practice had systems in place to protect patient confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with NHS England and Clinical Commissioning Group to secure improvements to services where these were identified.
- 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.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a vision and strategy to put patients first and deliver high quality care for patients.
- There was a clear leadership structure. The practice had policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of good quality care. This included arrangements to monitor and improve quality and identify risk.
- The principal GP encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents. Some staff were unclear about the duty of candour however.
- The practice monitored its performance but had not investigated areas where its performance was unusual, for example in some of its exception reporting.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. The practice included an alert for staff on the patient record for patients known to have enhanced needs.
- Patients at increased risk of dementia or falls were screened or assessed and referred to the relevant specialist teams.
- The practice provided the seasonal flu vaccination for patients over 65 and the shingles and pneumococcal vaccinations for eligible older patients.
- The practice maintained a palliative care register and as a team regularly reviewed patients on this list.

People with long term conditions

Good

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

- Longer appointments and home visits were available when needed.
- The practice ran case finding searches for patients with increased risk factors for long term conditions. Prevalence rates for several long term conditions were higher than the local average as a result.
- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. The practice provided parallel appointments for certain reviews such as diabetes so patients could see the health care assistant, nurse and GP as appropriate.
- The prevalence of diabetes locally was high. In 2015/16, 93% of diabetic patients had blood sugar levels that were adequately controlled compared to the CCG average of 77% and the English average of 78%.
- Nursing staff were trained to carry out diabetes, asthma and chronic obstructive pulmonary disease (COPD) reviews.
- Patients at risk of hospital admission were identified as a priority. For those patients with the most complex needs, the named GP worked with relevant professionals, community health and social services teams to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Good

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

- Appointments were available outside of school hours and the premises were suitable for children and babies. Baby changing facilities were available.
- The practice prioritised young children and babies for urgent or same-day appointments. Parents we spoke with said they were able to obtain appointments for young children without difficulty.
- The practice provided child immunisations. Immunisation rates were high for all standard childhood immunisations. The practice followed up children who did not attend for immunisation.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- In 2015/16, 85% of practice patients with asthma had an asthma review in the preceding 12 months compared to the national average of 76%

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 and was open until 6:30pm every weekday.
- The practice offered telephone consultations daily which were particularly useful for working patients.
- The practice offered a full range of health promotion and screening services appropriate for this group including catch up immunisations for children and 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 offered longer appointments for patients with a learning disability and other complex needs.

Summary of findings

- The practice regularly worked with other health care professionals for example health visitors, in the management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations, for example patients who became homeless.
- 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.

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).

- In 2015/16 all patients diagnosed with dementia had their care reviewed in a face to face meeting within the last 12 months.
- The practice screened patients for dementia and had increased its prevalence rate. Patients identified as at risk were referred to the local memory clinic. Patients with dementia were offered regular reviews at the practice.
- 94% of patients diagnosed with psychosis had a comprehensive, agreed care plan documented in the record, within the last 12 months, which is in line with the national average of 89%.
- The practice hosted a monthly clinic with a mental health worker for patients who required additional support, for example following discharge from acute care. The practice was successfully supporting a number of patients with enduring mental health problems in primary care as part of this programme.
- The practice was aware of the raised risk of post traumatic stress disorder (PTSD) and social isolation in some groups of patients, for example asylum seekers. The practice had a number of these patients from Sri Lanka and assessed their mental health with standardised screening tools translated into Tamil.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice received mixed results compared to the local and national averages. The survey programme distributed 361 questionnaires by post and 112 were returned. This represented 3% of the practice's patient list (and a response rate of 31%).

- 41% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 69% and the national average of 73%.
- 60% 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 79% and the national average of 85%.
- 87% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 85%.
- 83% of patients described the overall experience of this GP practice as good compared to the CCG average of 78% and the national average of 85%.

We spoke with eight patients during the inspection, five members of the patient participation group and received 53 completed patient comment cards. Patients were very positive about the practice, for example sometimes describing it as the best general practice they had experienced.

Patients were positive about the quality of consultations, the helpfulness of reception staff and the premises which had recently been improved. They gave us examples of being involved in decisions for example about maternity services and receiving good advice on managing health conditions. One patient told us the doctors took the time to communicate effectively with patients, for example with a hearing impairment. Some patients told us they had received good emotional support from their GP.

The most consistent criticism was about the appointment system which was also reflected in the national patient survey results although this came from a small minority of patients and comment cards. Several patients commented on the difficulty of booking a timely appointment when their condition was not considered urgent. Patients told us that when they did have urgent problems or their children were unwell they were able to obtain an appointment the same day.

The practice carried out its own patient survey every other year and participated in the 'Friends and family' questionnaire survey with positive results. It had an active patient participation group and members told us the practice was responsive to suggestions and had made improvements as a result of patient feedback, for example, recently employing a female GP and making improvements to the telephone system.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The practice should ensure that all staff members are clear about the duty of candour and their responsibilities. The practice should have a written policy and procedure for reference.
- The practice should carry out an annual audit of infection control in the practice to ensure that it is meeting current infection control guidelines.
- The practice should investigate areas where its performance was unusual, for example in some of its exception reporting.
- The practice should aim to increase the uptake for cancer screening programmes among eligible patients.
- The practice should continue to work to improve patient experience of booking an appointment and the ease of getting through to the practice by telephone.

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- The principal GP should ensure that all staff have a structured annual appraisal and are given sufficient support to complete agreed personal development goals.

Somerset Family Health Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Somerset Family Health Practice

Somerset Family Health Practice provides NHS primary medical services to around 3250 patients in Southall, West London through a 'personal medical services' contract. The provider runs services from two separate practices in West London. This report focuses on the service at Somerset Family Health Practice. The practice is located within Ealing Clinical Commissioning Group.

The current practice clinical team comprises the principal GP, three regular locum GPs, a nurse practitioner, a practice nurse, and two health care assistants. The practice also employs a practice manager, administrative and reception staff. The GPs typically provide around 13 sessions a week in total. Patients can choose to see a male or female GP. The practice was a teaching practice and sometimes took undergraduate medical students on placement.

The practice is open from 8.30am until 6.30pm during the week with the exception of Thursday when it closes from 1.30pm. Morning appointments are available from 9am and afternoon appointments until 6.30pm. Same day appointments are available for patients with complex or more urgent needs. The practice offers online appointment booking and an electronic prescription service. The GPs make home visits to see patients who are housebound or are too ill to visit the practice.

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

The practice population has a higher than average proportion of younger adults aged between 25 and 40. The population in the local area is characterised by average levels of income deprivation, low unemployment rates and average life expectancy. The practice population is ethnically diverse with a high proportion of Indian and Sri Lankan patients by cultural background.

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

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 5 July 2016. During our visit we:

- Spoke with a range of staff including the principal GP, a sessional GP, the practice nurse, the practice manager, a health care assistant and a receptionist.
- Observed how patients were greeted on arrival at the practice.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 53 comment cards where patients and members of the public shared their views and experiences of the service.
- Interviewed eight patients and five members of the patient participation group. The patients we spoke with included younger and older patients and parents.
- Reviewed documentary evidence, for example practice policies and written protocols and guidelines, audits and monitoring checks.

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

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

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

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

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

CQC had not previously inspected this practice.

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they were encouraged to report incidents. Incidents were reported to the practice manager and there was a recording form available on the practice's computer system.
- 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 prevent the same thing happening again. We saw a recent example involving a mix up with a vaccination where the family had been informed immediately.
- The practice could not show us any written policy or procedures for meeting the duty of candour and some staff were unclear about this. (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). However staff were aware of the importance of being open with patients and told us this was part of the practice culture. Key elements of the duty of candour were covered within the practice's significant event policy and procedure.
- The practice carried out a thorough analysis of the significant events and these were discussed at practice meetings. The practice kept a record of lessons learned and actions taken. The practice also shared learning with other organisations, for example the local pharmacy when appropriate.
- 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. For example, the nurse practitioner ran a search of patient records when relevant safety alerts were received to identify any patients whose treatment or prescribing might require review.

Overview of safety systems and processes

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

- Arrangements 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. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GPs and nurse practitioner were trained to child protection or child safeguarding level 3.
- Notices in the waiting room and in consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. However, the practice had not recently carried out an annual infection control audit in line with current guidelines.
- 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 pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. We noted that antibiotic prescribing levels were comparable to other practices in the CCG.

Good

Are services safe?

- The nurse practitioner had qualified as an independent prescriber and could therefore prescribe medicines for specific clinical conditions. Patient group directions (PGDs) had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).
- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had a comprehensive range of policies and procedures covering various aspects of health and safety. The practice had an up to date fire risk assessment and carried out regular fire safety checks and six-monthly fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. 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).
- 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.

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 secure areas of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through team discussion, appraisal, audit and checks of patient records.

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 were 95.5% of the total number of points available. The practice exception reporting rate was 16% overall which was above the clinical commissioning group (CCG) average of 11%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 showed:

- Performance for diabetes related indicators was above the national average. For example, 93% of diabetic patients had blood sugar levels that were adequately controlled (that is, their most recent IFCC-HbA1c was 64 mmol/mol or less) compared to the CCG average of 77% and the English average of 78%. The practice exception reporting rate was comparatively high for this indicator at 28% compared to the CCG rate of 17%.
- Eighty per cent of practice diabetic patients had a recent blood pressure reading in the normal range compared to the CCG average of 76% and the English average of 78%.
- Performance for mental health related indicators was comparable to the national average. In 2015/16, all patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months.
- For patients with a diagnosis of psychosis, 94% had a documented care plan in their records in the last 12 months. This was statistically comparable to the CCG and national averages (90% and 89% respectively). The practice was successfully supporting a number of patients with enduring mental health problems in primary care as part of a shared care programme in the clinical commissioning group area.

There was evidence of quality improvement including clinical audit.

- The practice participated in national benchmarking and locality based prescribing audits and reviews.
- The practice had carried out audits in the last two years. For example the practice had audited the use of non-approved blood glucose monitors amongst its diabetic patients and found that 4% were using non-approved monitors. As a result all but one of these patients had changed their monitor to an approved model. The practice carried out required ongoing audits for example annually reporting the rate of inadequate smears and it participated in ongoing prescribing audits organised by the CCG.
- The practice submitted another example of a repeated audit on the use of Quetiapine following the inspection. The audit included a rationale and a clear specification of the standards against which the practice was assessing its management. The practice submitted evidence of two separate audit cycles with changes to practice being sustained into the second cycle.

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.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.

Good

Are services effective?

(for example, treatment is effective)

- 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, an annual appraisal and locality based forums and networks.
- Most staff members had received an appraisal within the last 12 months. However one staff member had not had an appraisal for three years and we found that some staff members had not completed the objectives identified in their personal development plans.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- The practice sometimes offered teaching placements to undergraduate medical students.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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

The practice had a system for ensuring that test results and prescription changes were followed-up promptly. The receptionists kept a list of patients on the palliative care register to ensure they had timely access to primary and community services.

Multidisciplinary meetings took place with other health care professionals on a quarterly basis when care plans were routinely reviewed and updated for patients with complex needs.

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.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse practitioner assessed the patient's capacity and, recorded the outcome of the assessment.

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, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted or referred to relevant services including dietary and exercise programmes.
- The practice actively sought patients at risk of developing long-term conditions, for example patients with raised risk factors for diabetes. The practice referred all newly diagnosed patients with diabetes to a recognised structured education programme.
- In 2015/16, 88% of eligible female patients had a cervical smear in the previous five years which above the national average of 81%. The practice ensured a female sample taker was available. However, the practice exception reporting rate was very high for this indicator at 35% compared to the CCG rate of 10%.The practice had failsafe systems in place to ensure results

Good

Are services effective?

(for example, treatment is effective)

were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

- The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. In 2015, 59% of eligible women had attended for breast screening which was somewhat below the CCG average of 65%. Bowel cancer screening rates were also relatively low with uptake at 34% of eligible patients compared to the CCG average of 47%.
- Childhood immunisation rates were high and the practice was achieving childhood immunisation targets. For example, in 2015, 100% of eligible babies had received 'five in one' vaccination by the age of two years. For the preschool cohort, 94% had received the pertussis(whooping cough) vaccination and 94% their first MMR vaccination.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Any raised risk factors or abnormalities were followed up through a clinical consultation.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff were able to take patients to a more private area if they needed to discuss sensitive issues or appeared distressed.

The patient comment cards and patients we spoke with were very positive about the practice, for example sometimes describing it as the best general practice they had experienced. Patients were positive about the quality of consultations and the helpfulness of reception staff.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice results tended to be in line with the national average for satisfaction scores on consultations with GPs and nurses. For example:

- 91% 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%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 81% 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 93% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 82% and the national average of 91%.
- 67% of patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

The importance of treating patients with respect at reception had been discussed in practice meetings. The practice was also taking steps to improve the telephone system which it hoped would improve patient satisfaction with reception more generally.

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 gave us examples of being involved in decisions for example about maternity services and receiving good advice on managing health conditions. One patient told us the doctors took the time to communicate effectively with patients, for example with a hearing impairment. 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 also 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 local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 86%.
- 82% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and the national average of 82%.
- 88% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.

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

Good

Are services caring?

a number of support groups and organisations. Information about support groups was also available on the practice website. Some patients told us they had received good emotional support from their GP during difficult times or situations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 30 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if patients had suffered bereavement, their usual GP wrote to them and offered a consultation. The practice could give these patients advice on how to find a bereavement support service.

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) and other practices in the locality to secure improvements to services where these were identified. For example, the practice provided a range of diagnostic tests (such as ECG testing) to reduce the need for patients to travel to hospital outpatient clinics.

- The practice offered appointments until 6:30pm for patients who found it difficult to attend during normal opening hours. The practice had previously opened over the weekend but we were told that this did not prove popular enough with patients to justify continuing.
- There were longer appointments available for patients with a learning disability or other complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with more urgent medical problems.
- Patients were able to receive travel vaccinations. The practice informed patients in advance which vaccinations were available free on the NHS and about any which were available only on a private prescription basis and the associated fees.
- The service was accessible to patients with disabilities and a translation service was available. The practice was arranged over two floors and had lift access to the first floor. The practice did not have a hearing induction loop.

Access to the service

The practice was open from 8.30am until 6.30pm during the week with the exception of Thursday when it closed from 1.30pm. Morning appointments were available from 9am and afternoon appointments until 6.30pm. Same day appointments were available for patients with complex or more urgent needs. The practice offered online appointment booking and an electronic prescription service.

Results from the national GP patient survey showed that patient satisfaction with access to the service was variable and was markedly below the local and national averages for certain aspects of the service:

- 80% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and the national average of 78%.
- 41% of patients said they could get through easily to the practice by phone compared to the CCG average of 69% and the national average of 73%.
- 60% of patients said they were able to book an appointment to see or speak to a GP or nurse compared to the CCG average of 79% and the national average of 85%.

People confirmed on the day of the inspection that they were able to get appointments when they needed. However a consistent criticism during the inspection was about difficulties getting through to the practice by telephone. At the time of the inspection, the practice was in the process of improving the telephone system for example to include the facility for call waiting. The patient participation group told us this was something that had been discussed with them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

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

The practice had received two complaints in the last 12 months both about the helpfulness of the reception staff. These were responded to and investigated in line with the practice's complaints policy. The practice learnt from individual concerns and complaints and discussed patient feedback at practice meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice vision was to 'put patients first' and to deliver high quality care in partnership with patients.

- Patients we spoke with and staff consistently told us the practice provided a good service to the local community.
- The practice had a strategy and supporting business plans which reflected the vision. However most staff members were unaware of the strategy and some staff expressed some concern and uncertainty about the future.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained through the Quality and Outcomes Framework (QOF) and other measures. The nurse practitioner had a lead role, for example, on monitoring QOF. The regular locum GPs were less involved and had less awareness of how the practice performed against some local and national priorities.
- The practice generally performed well but we noted that exception reporting was high for certain indicators, particularly some diabetes indicators and for the cervical screening uptake rate. The practice had not investigated its exception reporting which it ascribed to the cultural characteristics of the population. The practice had not identified whether there were actions it could take to reduce exceptions in these areas.
- The practice carried out audits to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the principal GP demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us the principal GP was approachable and was accessible as they were normally based at the practice one day a week.

The provider had an effective procedure to manage significant events within the practice. Staff were aware of the procedures and the importance of being open with patients,although they were sometimes unclear about the duty of candour and the specific requirements of these regulations. (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). 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 said they were supported by the practice manager and their colleagues.

- The practice held regular team meetings and kept minutes of the discussion and any action points.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at any time.
- Most staff had annual appraisals and opportunities to develop a personal development plan. However there were some exceptions, in one case a member of staff had not had an appraisal for three years.

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 complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team.
- The PPG were very positive about the willingness of the practice to listen to feedback and take action. For

Are services well-led?

Good

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

example, the group told us about action the practice had taken to address the problem of patient queues outside the practice early in the morning. They told us this had been fully resolved as a result.

- The practice had gathered feedback from staff through practice meetings, appraisals and informal discussion. Staff told us they would not hesitate to give feedback and to raise any concerns. Staff we interviewed were aware of the whistleblowing procedure.

Continuous improvement

The practice was keen to improve and maintain its reputation. The practice participated in local improvement schemes to improve outcomes for patients, for example identifying patients at risk of unplanned hospital admission and proactively case managing their care. The practice was a teaching practice and sometimes provided undergraduate medical students with teaching placements. The principal GP was active in local politics with the ability to influence local and regional health priorities.