

Straight Road Doctors Surgery

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Requires improvement



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Straight Road Doctors Surgery on 14 April 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.
- 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 but were not always 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.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- The practice should review its procedure for identifying and assessing risks to patients and staff for example fire drills, medicines and basic life support training
- Ensure the practice actively identifies and supports patients who are also carers.
- Advertise that translation services are available to patients on request.
- Consider including details of how to access appointments at the local hub service on the practice website.

Summary of findings

- The practice should ensure patients are provided with suitable information about treatment options available, along with the benefits and risks and are fully involved in making shared decisions about their care.

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 providing safe services.

Good



- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Patients were at risk of harm because some systems and processes had weaknesses, for instance, not all staff had received up to date training in basic life support and the practice did not carry out regular fire drills.
- Risks to patients who used services were not always assessed. For instance, the practice did not have an automated external defibrillator (AED) and had not undertaken a risk assessment to identify if this was safe. A risk assessment had not been carried out to ensure the practice maintained an appropriate stock of emergency medicines.
- During and immediately following the inspection the practice ordered an AED, reviewed and increased its range of emergency medicines and had Basic Life Support training booked.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The practice had ensured that some vulnerable patients who were harder to reach for immunisations, annual reviews and other aspects of care were provided with a more flexible approach to appointments and consultation times to ensure they received a proper standard of care.
- 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.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

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

- Data from the national GP patient survey showed patients rated the practice lower than others for some aspects of care. The practice had engaged with the issues underlying the lower than average ratings and had taken action to improve services but the impact of actions taken had not yet been assessed.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Requires improvement



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team 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 a number of patients on its register who would regularly seek care at walk-in centres in different parts of the country. The practice had developed a protocol to ensure that requests for support for these patients from other practices were handled efficiently and securely.
- 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.

Good



Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Good



Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.

Good



- 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.
- GPs used a risk stratification tool designed to identify patients at highest risk of attending A&E or being admitted to hospital, and also to enable the GPs to have peer to peer discussions regarding patients with similar health concerns
- The practice provided a health check to all registered patients over the age of 75 years as part of the Everyone Counts Health Initiative.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were in line with national averages. For instance, patients with hypertension whose blood pressure was well controlled was 84% which was the same as the national average.
- The practice was participating in a CCG pilot scheme in which the practice was aligned to two local nursing homes. The practice had created two extra sessions per week which were exclusively reserved for residents in the nursing homes and this had improved continuity of care for these patients.
-

People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Outcomes for patients with long term conditions were in line with national averages. For instance, the percentage of patients with diabetes whose blood sugar was well controlled was 83% compared to the national average of 78%. The percentage of patients with chronic obstructive pulmonary disease (COPD) who had a review undertaken including an assessment of breathlessness was 98% compared to the national average of 90%.

Summary of findings

- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good



- The practice is rated as good for the care of families, children and young people.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 70%, which was lower than the CCG average of 77% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice provided confidential sexual health advice and chlamydia screening to younger people.
- The practice provided child health surveillance and six week check-ups, and offered health education to young parents.

Working age people (including those recently retired and students)

Good



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

Summary of findings

- The practice offered a 'Commuter's Clinic' on a Tuesday evening until 8:00pm for working patients who could not attend during normal opening hours.
- Each GP session included a number of telephone consultation slots for patients who were unable to attend in person or who were unsure if their condition required a visit to the surgery.
- The practice was part of a local co-operative and this meant it could offer appointments until 10:00pm on weekday evenings and between 8:00am and 8:00pm on Saturdays.
- Health checks for patients aged 40 to 74 and cardiovascular risk assessments were undertaken opportunistically and by invitation.

People whose circumstances may make them vulnerable

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 homeless people, travellers and those with a learning disability.
- The practice had a flexible approach to appointments for patients who were hard to reach for immunisations, annual reviews and long term condition management and would undertake a number of aspects of patient care during any appointment a patient attended.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Translation services were available for patients who did not have English as a first language but information about this was not readily available to patients.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



Summary of findings

- 77% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84%
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive agreed care plan documented in the record was 90%, the national average was also 90%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- Patients experiencing mental health conditions could book longer appointments.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing below local and national averages for some areas of patient care. 398 survey forms were distributed and 101 were returned. This represented 4% of the practice's patient list.

- 91% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 69% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 65% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 56% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the national average of 79%.
- 58% of patients stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care compared to the national average of 82%

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 42 comment cards, 40 (95%) of which had positive comments about the standard of care received. Patients commented about the caring nature of the doctors and the helpful attitude of the administration and reception staff. Patients commented that they could generally get appointments when they needed them. Of those comments that were not positive, patients mentioned the state of décor of the reception area and the difficulty in seeing their preferred GP.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. All three said they received a high standard of personalised care and that all staff had regard for their emotional and physical well-being.

Areas for improvement

Action the service **SHOULD** take to improve

- The practice should review its procedure for identifying and assessing risks to patients and staff for example fire drills, medicines and basic life support training
- Ensure the practice actively identifies and supports patients who are also carers.
- Advertise that translation services are available to patients on request.
- Consider including details of how to access appointments at the local hub service on the practice website.
- The practice should ensure patients are provided with suitable information about treatment options available, along with the benefits and risks and are fully involved in making shared decisions about their care.

Straight Road Doctors Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and a GP specialist advisor.

Background to Straight Road Doctors Surgery

Straight Road Doctors Surgery provides GP primary care services to approximately 2,600 people living in the Harold Hill neighbourhood of the London Borough of Havering. The practice is in an area that is in the third more deprived decile. The practice's patient age and gender profile is largely in line with national averages, with a slightly higher population of 40 to 50 year olds

The practice is run by two GP partners, one male and one female, both of whom work part time to provide a combined total of nine sessions per week. The practice provides GP services to two local nursing homes and provides an additional two sessions per week for this. There are two nurse prescribers and one practice nurse, all of whom work part time with a combined Full Time Equivalent of 0.5, a business manager and a practice manager. There are also two receptionists and two administration staff.

The Practice is registered with CQC as a partnership.

The practice is open between 8.30am and 1:00pm Monday to Friday and 4:30 and 6:30pm Monday to Wednesday and on Friday. The practice is closed from 1:00pm on Thursday

afternoons. Appointments are from 9.00am to 11.00am Monday to Friday and 5:00pm to 6:30pm Monday to Wednesday and on Friday. Extended surgery hours for pre-bookable appointments are available between 6:30pm and 8:00pm on Tuesdays.

Appointments can be booked up to two weeks in advance, and urgent appointments which can be booked the same day are available for people who need them. Patients could also book appointments 24 hours or 48 hours in advance.

Practice patients are directed to contact the local out of hours provider when the surgery is closed.

The practice operates under a General Medical Services (GMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These are:

Childhood Vaccination and Immunisation Scheme, Extended Hours Access, Facilitating Timely Diagnosis and Support for People with Dementia, Influenza and Pneumococcal Immunisations, Minor Surgery, Patient Participation, Rotavirus and Shingles Immunisation, Unplanned Admissions and Improving patient Access Online.

The practice was previously inspected in September 2013 under the previous methodology and was judged to be compliant.

The practice is registered to carry out the regulated activities of Diagnostic and screening procedures, Maternity and midwifery services and Treatment of disease, disorder or injury. During our inspection on 14 April 2016, we saw that the practice was carrying out minor surgery procedures. The practice had not registered for this

Detailed findings

regulated activity. We brought this to the attention of the practice who immediately suspended all minor surgery activity. An application to register the location for the regulated activity of minor surgery was received the morning after the inspection.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 April 2016. During our visit we:

- Spoke with a range of staff including GPs, nurses, the practice manager, the business manager and administration staff. We also spoke with the clinical lead of a nursing home and with patients who used the service.

- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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.

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 would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

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, we reviewed an incident in which a patient had signed the two pages that made up the practice consent form. One page was correctly attached to the patient record but a handling error meant that the second page was attached to an incorrect patient record. This error was identified and discussed at a staff meeting. As a result of the incident and the discussion, the practice redesigned the consent form to consist of a single page to prevent this error happening again.

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 did not always attend safeguarding meetings as these were usually held during surgery hours but 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. GPs and nurses were trained to child protection or child safeguarding level 3. Contact details for local safeguarding agencies were immediately available to all staff.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role but only the nurses had received a Disclosure and Barring Service (DBS) check. The practice had undertaken a risk assessment of having staff acting as chaperones without a DBS check and had assessed this as a low risk as chaperones were never alone with patients without clinical supervision. (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. Annual infection control audits were undertaken and we saw evidence that remedial action had been taken for urgent areas of concern. For example, the most recent audit had noted cleaners mops were left wet in the cleaning buckets which is a hazard. Following the audit, the practice ensured mops were removed from buckets and fixed to the wall to hang upside down after cleaning is completed. Firm plans were in place to meet recommended timescales for other areas of concern.
- 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

Are services safe?

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. Two of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications had been undertaken for all staff, and registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service had been undertaken for all clinical staff. The practice had undertaken a risk assessment of not undertaking DBS checks for non-clinical staff. They assessed this as low risk as all staff had received information governance and safeguarding training, had signed confidentiality agreements, and were never alone with vulnerable patients.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and an evacuation plan which included details of individual responsibilities and procedures. Although there was no record of recent regular fire drills, staff we spoke with were able to describe the practice's evacuation plan and were able to describe how to use the IT system to ensure that all patients were accounted for in an emergency.
- 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. The practice had ensured that all administration staff were multiskilled so that absences could be managed using existing resources. Staff we spoke with told us that they were able to manage their workloads comfortably.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to some emergencies and major incidents although there were areas where arrangements were not as strong

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had received annual basic life support training but this had not been updated for two years for some staff and four years for others. We were shown evidence that this training had been booked for all staff and was due to take place within four weeks from the date of our inspection.
- There were emergency medicines available in the treatment room. We noted that the practice had not undertaken a risk assessment to decide which emergency medicines should be held at the practice. For instance, the practice carried out minor surgery procedures but did not keep a supply of Atropine (a medicine used to treat an abnormal heart rhythm), along with other medicines used to treat medical emergencies. This meant the provider was unable to demonstrate that they had appropriate medicines nearby to treat medical emergencies should they arise. We discussed this with the GPs and saw evidence that Atropine and several other emergency medicines were ordered the day after our inspection.
- The practice had oxygen with adult and children's masks on the premises. A first aid kit and accident book were available. There was no defibrillator on the premises and this had not been risk assessed. We

Are services safe?

discussed this with the practice who undertook an immediate review of this provision. We saw evidence that a defibrillator had been ordered before we left the practice.

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage and this had been reviewed in November 2015.

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 risk assessments, audits and random sample checks of patient records.
- GPs used a risk stratification tool designed to identify patients at highest risk of attending A&E or being admitted to hospital, and also to enable the GPs to have peer to peer discussions regarding patients with similar health concerns

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 99.8% of the total number of points available.

The practice had higher than average exception reporting rates for atrial fibrillation, chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis. The practice were fully aware of these rates and were able to demonstrate that patients were being properly excepted but that the low numbers of patients on these registers meant that just a small number of exceptions could represent a large percentage of this patient group.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was in line with the national average. For instance, the percentage of patients with diabetes, on the register whose blood sugar was well controlled was 83% compared to the national average of 78%.

- Performance for mental health related indicators was comparable to the national average. For example, 91% of patients with schizophrenia, bipolar affective disorder and other psychoses who had an agreed care plan compared to the national average of 88%.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness was 98% compared to the national average of 90%.

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits completed in the last two years. One of these was a completed audit of the practice's end of life care. As a result of this audit, the practice had amended it's end of life care protocol to provide better support to patients with a preferred place of death to ensure that this preference was realised wherever possible.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, following an audit of patients with COPD, the practice had been able to prescribe a different type of medication for some patients which had fewer side effects and reduced prescribing costs.

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 clinical staff, for example, for those reviewing patients with long-term conditions. We reviewed the training records of the nurses and saw evidence of suitable training and updates.
- 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.

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- All staff were provided with one half day of protected learning time each month and this included non-clinical staff.

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.
- The practice had identified a number of patients who regularly used walk-in clinics in different parts of the country and had developed a protocol that these patient's notes could be shared securely with other clinicians when they were needed. This had improved the standard of care these patients were able to receive.
- The practice had a failsafe system to ensure that patients referred for two week wait appointments received appointments and had a process for those who did not attend these appointments. Patients who failed to attend were contacted and given support to engage with the referral process.
- There were monthly meetings with the local integrated care and palliative care teams

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly 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 practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.
- The practice gained written consent for minor surgery procedures and cervical smear testing and this was attached to patient records. Verbal consent was sought for other procedures such as immunisations and this was also added to patient records.

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 to the relevant service.
- The practice maintained a register of patients requiring palliative care and patients who may have difficulties identifying or engaging with ways of living healthier lives, including patients with learning difficulties, patients experiencing poor mental health and homeless patients.
- The practice had identified that some of its younger population were sexually active relatively early in their lives. Clinicians told us that in addition to ensuring that they provided suitable sexual health services including screening and testing, they also talked to these patients about sexual health and were able to demonstrate knowledge of Gillick competence and Fraser guidelines. (Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used to decide if a child can consent to contraceptive or sexual health advice and treatment.)

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 70%, which was lower than the CCG average of 77% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice had recently reviewed uptake rates for bowel screening and identified that only 27% of those invited for screening took up the invitation within six months (compared to the CCG average of 55% and national average of 55%). As a result, the practice had held a meeting with a Macmillan GP in January 2016 and had developed an action plan to improve the uptake rate. This included improving the use of system alerts to identify non-attenders for recall actions and involving the PPG in planning an education campaign. (Macmillan GPs are practising GPs who devote an average of a day per week to work with Macmillan to make a recognisable improvement in cancer care across the UK.)

There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given to under two year olds ranged from 67% to 80% and five year olds from 62% to 76%. Comparative data was not available for CCG or national rates.

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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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice was participating in 'Everyone Counts', a scheme intended to optimise care for elderly patients (patients aged over 75).

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Of the 42 patient Care Quality Commission comment cards we received, 40 were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 61% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- 66% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 80% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 60% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.

- 81% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

The practice were aware of the results from the national GP survey and had identified those areas where responses were below average and had commissioned a second survey using an online survey organisation to produce further information. This survey received 52 responses and the practice explained that this had helped them to better understand some of the underlying issues which may have been contributing to the dissatisfaction in the national GP survey. For instance, the practice provided GP services for two local nursing homes and the practice identified that a significant amount of clinician and administration time was being used to manage communications with these organisations. The practice had put two new GP sessions in place which were entirely dedicated to the nursing homes. The practice and the nursing homes had discussed communication arrangements and had agreed that requests for non-urgent information or support would be made in a single written submission once per day rather than via multiple telephone calls. This had made a significant improvement to patient access and allowed GPs more time with patients visiting the surgery. Patients we spoke with told us they felt they had enough time with GPs, did not experience unreasonable delays in the waiting area and were able to make appointments at times that suited them. Comments received on patient feedback cards aligned with these views.

Care planning and involvement in decisions about care and treatment

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

The practice had reviewed its end of life care in early 2015 and had developed a protocol to improve this provision and this had included working with the nursing homes for

Are services caring?

which the practice had GP responsibility. The palliative care patient register had been increased from the national standard of 1% to 2% and GPs and staff undertook specialised end of life care training. In March 2016, the practice undertook a review of recent patient deaths and reported that 70% of patients on the palliative care register who had died, had died in their preferred place of death. Comparative figures for previous years were not available.

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

- 63% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and the national average of 86%.
- 58% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 91%)

We discussed these results with the practice and they described how they had changed some aspects of how they discussed conditions and treatments with patients. For instance, GPs told us that when discussing medication or other treatment, they would take more time to ask patients about whether previous treatments had been effective and would spend time discussing and listening to patient's views on side effects.

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, although we did not see this information displayed where patients could see it.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified ten patients as carers which represented 0.4% of the practice list, however we did not see evidence they were proactively trying to identify carers. Carers were offered a priority annual flu immunisation and were signposted to support organisations when that was helpful.

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

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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered a 'Commuter's Clinic' on a Tuesday evening until 8:00pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability, patients with complex conditions and patients experiencing poor mental health.
- 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 medical problems that require same day consultation.
- Homeless patients could register using the practice address.
- The practice had a number of traveller families on its register and the practice told us they were particularly flexible about the length of consultation time given to these patients. The practice explained that some traveller patients could be difficult to contact for immunisations, annual reviews or management of long term conditions so these were undertaken opportunistically if the patient made any appointment.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- The practice had limited disabled facilities. For instance, there was step free access and all consulting and treatment rooms were on the ground floor and were fully accessible. The patient toilet was also on the ground floor and whilst fully accessible, did not have disabled toilet furniture and there were no handrails or emergency alarm. The practice did not have a hearing loop. Translation services were available but there were no signs to inform patients who needed this service. The practice had received planning permission to undertake works to improve the premises and this included improving disabled facilities.

The practice were participating in a CCG funded 'nursing home alignment' scheme and was responsible for providing services to two homes, one with 28 patients and another with 60 patients. (The nursing home alignment scheme involves each home aligning with a single GP surgery for the provision of services rather than several GPs attending to their own patients at different times). The practice had added two extra GP sessions per week and these were exclusively for the care of patients in these homes. GPs undertook ward rounds, medication reviews, annual reviews and management of long term conditions during these sessions and had included these patients in their QOF returns. We spoke to a management representative of the larger nursing home (60 patients). They told us the practice was very responsive and that the use of a single GP provider had reduced the amount of time the home needed to spend chasing results or appointments. CCG data indicated that this scheme had reduced hospital admissions for these patients by 14% and that prescribing audits had shown a reduction in anti-psychotic drug prescriptions.

Access to the service

The practice was open between 8.30am and 1:00pm Monday to Friday and 4:30 and 6:30pm Monday to Wednesday and on Friday. The practice was closed from 1:00pm on Thursday afternoons. Appointments were from 9.00am to 11.00am Monday to Friday and 5:00pm to 6:30pm Monday to Wednesday and on Friday. Extended surgery hours for pre-bookable appointments were available between 6:30pm and 8:00pm on Tuesdays.

The practice had a contractual arrangement with an out of hours provider to provide services from 8:00am to 9:00am on Monday to Friday as well as from 1:00pm to 6:30pm on Thursdays. This out of hours provider also provided services when the practice was closed from 6:30pm to 8:00am and on Saturdays and Sundays.

The practice had joined a co-operative group of local GP practices and appointment slots were available at a local hub between 6:30pm and 10:00pm every weekday evening as well as on Saturdays between 8:00am and 8:00pm. These appointments could be booked in advance through the surgery or directly by patients themselves, although we did not see information about this in the waiting area or on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them. Appointments could be booked further in advance if a GP or nurse requested this, for instance to follow up on treatment or to review a condition. Telephone consultation appointments were available during every GP session.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages.

- 70% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 91% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. The practice was aware that GP opening hours was an issue for its practice population and explained that by joining the local GP co-operative they had been able to provide their patients with access to a GP at times that were previously prohibitive to a small practice.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. We were told that although verbal complaints were taken seriously and were investigated and patients given apologies and explanations, only written complaints were formally recorded.

- 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 displayed in the waiting area to help patients understand the complaints system

The practice had received one written complaint in the last 12 months and there were no reviews of the practice on the NHS Choices website in the last 12 months. The complaint had been handled in an appropriate way and the patient had received a written apology. Lessons were learnt from this complaint.

Are services well-led?

Good 

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

Our findings

Vision and strategy

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

- The practice did not have a written mission statement displayed in the waiting areas but staff knew and understood the values held by the GP partners.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. GPs were aware of the limitations of the physical environment itself and had created plans to develop the exiting premises and had received outline planning permission for this. The practice had also developed a contingency plan to amalgamate with another practice and relocate to a purpose built health centre.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used 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 partners in the practice told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when

things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. 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

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

- Staff told us the practice held regular team meetings. There were minuted meetings but other meetings were impromptu and were held to discuss more routine issues as they arose.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff told us the practice organised a number of social events and these were perceived as opportunities for team bonding as well as being a form of appreciation.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

• The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had been involved in reviewing the practice's telephone answering performance. The PPG also told us that they were providing support to the practice in developing plans to expand the practice.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us

Are services well-led?

Good 

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

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had participated in a CCG funded 'nursing home alignment'

scheme and this had reduced hospital admissions for residents of these homes by 14%. To ensure that a suitable amount of time was available to residents in the nursing homes without reducing access for other patients on the register, the practice had added two extra GP sessions each week, reserved exclusively for nursing home residents. The practice had reviewed its end of life care provision and had adopted the principles of the gold standard framework for end of life care for patients. The practice had been invited by the CCG to participate in a study of the disparity of end of life care across individual practices and localities.