

# Old Parsonage

## 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?

Requires improvement



Are services effective?

Good



Are services caring?

Good



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 Old Parsonage on 7 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 for reporting and recording significant events.
- The practice had arrangements to deal with emergencies and major incidents.
- 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 was available and easy to understand. The practice had a comprehensive complaints policy.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw the following area of outstanding practice:

- The practice reported all clinical significant events to the National Reporting and Learning System (NRLS), a central database of patient safety incident reports which are analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

# Summary of findings

The areas where the provider must make improvements are:

- Ensure clinical hand-wash basins comply with current Department of Health guidance.
- Ensure current best practice for the safe transportation of liquid nitrogen is followed.
- Revise risk assessment and management to include all risks associated with substances hazardous to health and emergency equipment.

In addition, the areas where the provider should make improvements are:

- Revise emergency equipment to ensure that children's oxygen masks are readily available.
- Improve patient privacy in the nurse treatment/minor surgery room.
- Ensure patients with long-term conditions have a written care plan.

**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 requires improvement for providing safe services.

**Requires improvement**



- Not all risks to patients who used services were assessed and the systems and processes to address these risks were not always implemented well enough to ensure patients and staff were kept safe. For example, those relating to the safe transportation of liquid nitrogen.
- There was an effective system for reporting and recording significant events, which included the reporting of all clinical significant events to the National Reporting and Learning System (NRLS).
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.

### 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 was unable to demonstrate there were written care plans for patients with long-term conditions.
- 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?

The practice is rated as good for providing caring services.

**Good**



# Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However, there were no curtains around the examination couch in the nurse's room/minor surgery room.
- 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.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice had fully considered the needs of some of its local population groups and secured improvements to services where these were identified, such as offering a drop-in children's clinic.
- 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 to patients.

## Are services well-led?

The practice is rated as requires improvement for being well-led.

Good



- There was an overarching governance framework which supported the delivery of the strategy and good quality care. However, the arrangements to monitor and improve quality and identify risk were not always effective.
- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the ethos of the practice and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- 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 for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken

# Summary of findings

- 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.

- 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.

Good



### People with long term conditions

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

- Nursing staff had been trained in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 87%, compared to the clinical commissioning group (CCG) and national average of 88%.
- 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. However, they did not all have a written care plan, although the practice told us that they planned to introduce these but were unable to confirm when this would happen.
- The practice offered in-house spirometry testing for patients with asthma and chronic obstructive airways disease.

Good



### Families, children and young people

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

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Good



# Summary of findings

- 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 89%, which was comparable to the CCG average of 84% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The practice offered weighing services to patients with young babies.
- There were chlamydia testing kits in discreet packaging in the vestibule so that young people could test themselves without having to see a doctor or nurse.
- One GP held a weekly clinic at a local boarding school for children who were resident there.
- The practice held a weekly children's drop-in clinic where children could see the doctor without an appointment.

## Working age people (including those recently retired and students)

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 offered late appointments on Mondays and Wednesdays for people who found it difficult to access the practice during core working hours.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



## 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 offered longer appointments for patients with a learning disability.

Good





# Summary of findings

- 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.

## 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).

- 92% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed, documented care plan was 100%, compared to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those 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 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.

Good



# 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 better than local and national averages. Two hundred and thirty survey forms were distributed and 130 were returned. This represented 4% of the practice's patient list.

- 100% of respondents found it easy to get through to this practice by telephone compared to the clinical commissioning group (CCG) average of 76% and the national average of 73%.
- 96% of respondents were able to get an appointment to see or speak with someone the last time they tried compared to the CCG average of 81% and the national average of 76%.
- 97% of respondents described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- 97% of respondents said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 82% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 44 comment cards all of which were positive about the standard of care received. Patients who completed comment cards told us that they found all staff at the practice to be kind and caring. Eight comments specifically related to the high standards of cleanliness in the practice, and twelve respondents told us that they found it easy to access appointments.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. All patients who completed the practice's friends and families test surveys in the three months prior to our inspection said they would recommend the practice to their friends and families.

# Old Parsonage

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

### Background to Old Parsonage

The Old Parsonage is situated in Goudhurst, Kent and has a registered patient population of approximately 3,622. The practice patient population includes a larger than average proportion of people aged 10-19 and 45-55 and a smaller than average proportion of people aged 20-40. The practice is located in an area with a lower than average deprivation score.

The practice staff consists of two full-time GP partners, one male and one female, and one full-time practice nurse (female). There is a practice administrator as well as reception staff.

All patient areas are on the ground floor and are accessible to patients with mobility issues, as well as parents with children and babies. There is sufficient parking for patients at the practice.

The practice has a general medical services contract with NHS England for delivering primary care services to the local community. The practice is not a teaching or a training practice (teaching practices have medical students and training practices have GP trainees and FY2 doctors).

The practice is open Monday to Friday between the hours of 8am and 6.30pm. Extended hours surgeries are available on Monday and Wednesday evenings from 6.30pm to 7.15pm.

There is a range of clinics for all age groups. There are arrangements with other providers (Integrated Care 24) to deliver services to patients outside of the practice's working hours.

Services are provided from Old Parsonage, Back Lane, Cranbrook, Kent, TN17 1AN.

### 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 7 July 2016. During our visit we:

- Spoke with a range of staff (one GP partner, the practice administrator, the practice nurse and two members of the reception staff) and spoke with five patients who used the service.
- Observed how patients were being cared for.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

# Detailed findings

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

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

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

- Older people

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

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

# Are services safe?

## Our findings

### Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there were recording forms available in a folder in the reception area. 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). The practice reported all clinical significant events to the National Reporting and Learning System (NRLS), a central database of patient safety incident reports which are analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.
- 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 saw evidence of discussion of an incident where a contractor stepped on a rotten drain cover and although no injury was sustained, the incident was investigated and steps taken to avoid its repetition. We also saw that the fact that the visitors' signing in book had not been taken from the building during a fire drill had been recorded as an incident and that staff had been reminded of the correct fire drill process.

### Overview of safety systems and processes

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

- There were arrangements 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 and there was a flow chart for staff to follow when reporting a concern. There was a lead GP for safeguarding adults and children. 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. GPs and the practice nurse were trained in child protection to child safeguarding level 3 and in adult safeguarding. Administrative staff had received safeguarding awareness training.

- Notices in the waiting room and in each of the consulting rooms advised patients that chaperones were available if required. Staff told us that the nurse carried out chaperone duties. There was a chaperone policy which provided guidance for staff.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was a cleaning schedule and staff completed this to show what cleaning had been completed. 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 and staff had received up to date training.
- Clinical wash-hand basins at the practice did not comply with Department of Health guidance. For example, some clinical wash-hand basins contained overflows and plugs. There was, therefore, a risk of cross contamination when staff used them. The practice was unable to demonstrate that there were plans to replace these basins at their next refurbishment. The infection prevention risk assessment failed to identify risks associated with clinical wash-hand basins that were non-compliant with national guidance.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice helped keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). There were processes 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 clinical commissioning group (CCG) pharmacy teams, to help

# Are services safe?

ensure prescribing was in line with best practice guidelines for safe prescribing. The practice received and acted upon Medicines & Healthcare products Regulatory Agency (MHRA) drug safety updates. Blank prescription forms and pads were securely stored and there were systems to monitor their use. The serial numbers of prescription pads were recorded when removed from the practice by GPs. However, the practice did not record the serial numbers of prescription forms for use in the practice's printers. We raised this with the practice who immediately introduced a system to do this and we saw evidence that this was implemented. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- The practice undertook cryosurgery requiring the use of liquid nitrogen. The practice did not keep stocks of liquid nitrogen on the premises. We were told that a member of staff collected the liquid nitrogen from another practice and transported it in their car. This did not comply with current best practice for the safe transportation of liquid nitrogen.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, and registration with the appropriate professional body.

## Monitoring risks to patients

Risks to patients were not always assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. However, these were not always effective. For example, risks relating to the safe transportation of liquid nitrogen were not well managed.
- 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 carried out regular fire drills. All electrical equipment was checked to help ensure the equipment was safe to use and clinical equipment was checked to help ensure it was working properly. The practice had a variety of other risk assessments 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).

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The GPs provided cover for each other's absences. There was a rota system for reception staff to help ensure enough staff were on duty.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements to respond to emergencies and major incidents.

- There was a panic alarm system in all the consultation and treatment rooms which alerted staff to any emergency. There was a protocol for the use of the panic alarm that guided staff on how they should respond.
- 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 an adult mask. However, there was no children's oxygen mask available. When we brought this to the attention of the practice, they ordered a children's mask immediately. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

# 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 to help keep all clinical staff up to date. GPs and the practice nurse 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.

### 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 recently published results were 97% of the total number of points available. Exception reporting was low. (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). For example, exception reporting for diabetes was 3% compared to the clinical commissioning group (CCG) and national average of 11%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators was similar to local and national averages. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 87%, compared to the CCG and national average of 88%.
- Performance for mental health related indicators was better than local and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 100% compared to the CCG and national average of 88%.

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, the practice had undertaken an audit of spirometry test interpretation in 2015 as a result of lower than expected prevalence of chronic obstructive pulmonary disease (COPD). (Spirometry is a test used to assess how well a person's lungs work) This had identified that, although the practice could demonstrate that the spirometer had been tested, it was not functioning properly and the practice had replaced the equipment.

### 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. Each member of staff had a checklist to help ensure they received training including 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, reception staff had received training in customer service and in dealing with repeat prescriptions.
- 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,



# Are services effective?

## (for example, treatment is effective)

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.

- Staff received training that included: safeguarding, fire safety awareness, basic life support, equality and diversity and information governance. Staff had access to and made use of e-learning training modules and in-house training.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system.

- Risk assessments, medical records, alerts and investigation and test results were available to staff. However, patients receiving care for long term conditions did not have a written care plan. The practice told us that they planned to introduce these but were unable to confirm when they would address this deficit.
- 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 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 bimonthly basis when care plans were routinely reviewed and updated for patients with complex needs. For example, we saw minutes of palliative care meetings held by the practice which were attended by the GPs, district nurses, hospice nurse and a social care co-ordinator.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. There was a consent policy which reflected the practice's understanding of specific issues relating to children and people who lacked mental capacity.

- 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.

### 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 cessation and alcohol consumption. Patients were signposted to the relevant service.
- A range of patient information leaflets was available in the entrance to the practice.
- There were chlamydia testing kits in discreet packaging in the vestibule so that young people could test themselves without having to see a doctor or nurse.

The practice's uptake for the cervical screening programme was 89%, which was comparable to the CCG average of 84% and better than the national average of 82%. 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. There were systems to help ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were similar to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 76% to 97% (CCG 69% to 91%) and five year olds from 93% to 98% (CCG 82% to 95%).

Patients had access to appropriate health assessments and checks via an arrangement with the local pharmacy. NHS health checks were undertaken at the local pharmacy and the practice received information about any patients who



# Are services effective?

(for example, treatment is effective)

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

# 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.

- The doctors' consulting rooms had separate examination rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. However, in the nurse's room, which was also used for minor surgery, there were no curtains around the examination couch which was in the centre of the room with the foot end pointing towards the door. Staff told us that they locked the door while treatment or examinations were taking place and that they turned their backs while patients were changing. They also told us that they were considering putting up a privacy curtain between the couch and the door but did not have a written action plan to address this.
- We noted that consultation and treatment room doors were closed during consultations; however, conversations taking place in these rooms could be overheard in the corridor. The waiting area was separate from the corridor to the consulting rooms and a radio was playing in the waiting area to create background noise. This minimised the risk of confidential conversations being overheard.
- Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 44 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Thirty comments expressed a high level of satisfaction with the care patients received from doctors, nurses and other staff. Twelve patients who completed comment cards specifically commented that they felt the appointment system was effective.

We spoke with a member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said that staff were very caring. 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 significantly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of respondents said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 100% of respondents said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 100% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 100% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and the national average of 85%.
- 100% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 94% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

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

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We 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 higher than local and national averages. For example:

- 99% of respondents said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.

## Are services caring?

- 98% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 82%.
- 99% of respondents said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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. We saw notices in the reception areas informing patients this service was available.

### **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 63 patients as carers (2% of the practice list). Staff told us that carers were referred to the social care co-ordinator who visited the practice. Written information was available to direct carers to the various avenues of support available to them.

The practice used a checklist for patients who were receiving end of life care. This helped ensure that they met the National Gold Standards Framework (GSF) for end of life care.

There was a protocol for staff to follow if families had suffered bereavement and a message was added to the bereaved person's record to alert staff. Their usual GP contacted them by telephone. This call was either followed by a 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. The protocol also helped to ensure that all other services providing care were informed of a patient's death.

# 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 patient 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 late appointments on a Monday and Wednesday evening until 7.15pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- 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.
- Patients were able to receive travel vaccinations available on the NHS and were signposted to other clinics for vaccines only available privately.
- There were disabled facilities and translation services available. The practice's hearing loop was broken but the practice had taken action to arrange for it to be repaired
- There was a weekly children's clinic that parents could attend with children without an appointment.
- One GP held a weekly clinic at a local boarding school for children who were resident there.
- The practice offered weighing services to patients with young babies.

### Access to the service

The practice was open Monday to Friday between the hours of 8am and 6.30pm. Appointments were available from 8.30am to 10am every day with no pre-booking required. Bookable appointments were available from 3.30pm to 6pm and 4pm to 6pm on Friday. Extended hours surgeries were available on Monday and Wednesday evenings from 6.30pm to 7.15pm.

In addition to pre-bookable appointments that could be booked up to six months in advance, urgent appointments were also available for people that needed them.

The patients we spoke with, and those who completed comment cards, told us that the appointment system worked well and that they found it easy to see a doctor.

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

- 92% of respondents were satisfied with the practice's opening hours compared to the CCG and national average of 78%.
- 100% of respondents said they could get through easily to the practice by telephone compared to the CCG average of 76% and the national average of 73%.

The practice had a system to assess:

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

Staff told us that some patients were flagged on their system as needing home visits, and that GPs would consider requests for home visits from other patients on the basis of clinical need. 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 a system for handling complaints and concerns.

- The practice had a complaints policy and procedures which were in line with contractual obligations for GPs in England.
- The practice administrator was the designated responsible person who handled all complaints in the practice.
- The practice had a complaints leaflet to help patients understand the complaints system. However, this was not specific to the practice and was not readily available in the waiting room. A notice in the waiting room advised patients that they could speak to the practice administrator if they wished to complain and staff told us that they would give the complaints leaflet to patients on request.

The practice had not received any complaints in the last 12 months.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

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

- The practice had a mission statement and staff knew and understood the values of the practice.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

The practice had a nominated clinical lead for governance and an overarching governance framework which supported the delivery of the strategy and good quality care.

- 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 in a central folder. Members of staff had a list of which policies were available for ease of reference.
- A comprehensive understanding of the performance of the practice was maintained. However, patients receiving care for long term conditions did not have a written care plan.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. For example, an audit of high risk antibiotic prescribing in 2014 had led to a reduction in their use in 2015.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, risks relating to the safe transportation of liquid nitrogen were not well managed.

### Leadership and culture

On the day of inspection the partner in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They 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 to help 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 to help 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 and staff felt supported by management.

- Staff told us the practice held regular team meetings. We saw comprehensive minutes of formal practice meetings which were held every three months. The partners and the practice administrator held weekly meetings which were not formally minuted, although records of key action points were kept.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example, the practice had purchased new electrocardiogram (ECG) equipment following a suggestion from the practice nurse.

### 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 an active patient participation group (PPG) which met with senior managers of the practice

# Are services well-led?

Good 

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

regularly and put forward suggestions for improvements at the practice. For example, the PPG had been involved in purchasing healthy eating related artwork from a local artist for the waiting area.

- The practice had gathered feedback from patients through the 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 collated responses to the practice's friends and family test and discussed these with the practice at meetings.
- The practice had carried out a survey of patients' views before introducing a radio in the waiting area to create background noise.

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

## 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. GPs and the practice nurse held regular meetings with colleagues from other neighbouring practices to share best practice.

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulation was not being met:</b></p> <p>The registered person did not do all that was reasonably practicable to ensure that there was sufficient equipment to ensure the safety of patients because they did not have any children's oxygen masks. They did not ensure the proper and safe management of substances hazardous to health because they did not follow current best practice on the safe transportation of liquid nitrogen.</p> <p>They had failed to identify and manage the risks associated with the spread of infections because they had not identified that the clinical wash-hand basins at the practice did not comply with Department of Health guidance and they were unable to demonstrate that there were plans to replace these basins.</p> <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>