

Dr AD Pullan & Partners

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Requires improvement



Are services well-led?

Good



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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Requires Improvement overall. We previously inspected the service on 25 November 2014 and rated the service Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students) – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at AD Pullan & Partners on 22 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had systems, processes and practices in place to protect people from potential abuse. Staff were aware of how to raise a safeguarding concern and had access to internal leads and contacts for external safeguarding agencies.
- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes but did not share learning practice wide or carry out a regular analysis of incidents to identify common trends.
- There were systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff.
- The practice reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The partners had reviewed and increased its workforce and employed additional clinicians to help meet the health needs of patients and the demand for access to appointments.
- Staff had received essential training to enable them to carry out their duties safely.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

Summary of findings

- Patient satisfaction with their experience of contacting the practice and making appointments continued to be below local and national averages. Feedback we received on the day of the inspection and in completed CQC comments cards, showed this was starting to improve following the implementation of a new telephone system and more staff available to answer telephone calls during peak periods. However, a small number of patients told us they still encountered problems with accessing appointments which was also reflected in reviews left on NHS Choices website. The practice was actively continuing to monitor the situation.
- The practice worked proactively with the local community and patient participation group (PPG) to meet the needs of their patients and the local population.
- There was a focus on learning and improvement at all levels of the organisation.
- Review the process for recording, sharing and learning from significant events and carry out a regular analysis to identify common trends and themes.
- Review the storage and security of oxygen cylinders held at the practice.
- Consider reviewing and reorganising staff recruitment files so they are clearly organised and contain all of the required information.
- Ensure policies and procedures that govern activity are clearly accessible, dated, reviewed to reflect practice and shared.
- Review the monitoring of uncollected prescriptions.
- Take a more proactive approach to identifying carers.
- Strengthen the management of complaints.
- Continue to review and improve patient access to the service.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

The areas where the provider **should** make improvements are:

Dr AD Pullan & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr AD Pullan & Partners

Dr AD Pullan and Partners, also known as Furlong Medical Practice is located in Tunstall, Staffordshire and delivers regulated activities from this practice only.

The practice is registered with the CQC as a partnership provider and holds a General Medical Services (GMS) contract with NHS England and provides a number of enhanced services to include minor surgery. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract. The practice is part of the NHS Stoke On Trent Clinical Commissioning Group (CCG) and is a training practice for GP Registrars and medical students to gain experience in general practice and family medicine.

The practice treats patients of all ages and provides a range of medical services. At the time of the inspection the practice had 10,125 registered patients. The practice area is one of high deprivation when compared with the local and national averages. The practice has 66% of patients with a long-standing health condition compared to the CCG average of 57% and the national average of 53%, which could mean an increased demand for GP services.

The practice staffing comprises:

- Six GPs (three male and three female)
- One advanced nurse practitioner, five practice nurses and two health care assistants.
- A practice manager, an interim practice manager, project co-ordinator, caretaker and a team of customer care and administrative staff.
- Three GP Registrars and a final year medical student

Opening hours are between 8am and 6pm Monday, Wednesday and Friday. Tuesday 7am and 8pm and Thursday 8am and 4pm. The practice is closed on Saturdays and Sundays and has opted out of providing cover to patients in the out-of-hours period. During this time services are provided by Staffordshire Doctors Urgent Care, patients access this service by calling NHS 111.

Additional information about the practice is available on their website: www.furlongmedicalcentre.gpsurgery.net

Are services safe?

Our findings

- **We rated the practice as good for providing safe services and good across all population groups.**

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were accessible to staff. Staff knew how to identify and report safeguarding concerns and had access to internal leads and contacts for external safeguarding agencies as previously recommended. Staff had received safeguarding training relevant to their role.
- The practice had a range of safety policies in place but not all of these were readily accessible or named and dated by the author.
- There were systems in place for identifying, assessing and mitigating risks to the health and safety of patients and staff. We saw a range of safety checks were undertaken and recorded.
- We saw the practice carried out recruitment checks on new staff, including checks of professional registration where relevant, on recruitment and on an ongoing basis. However, staff files we reviewed were not clearly organised and a satisfactory assessment relating to staff physical and mental health conditions had not been obtained. Disclosure and Barring Service (DBS) checks were undertaken where required. (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 had a chaperone policy in place. There were designated staff who acted as chaperones and were trained for the role and had received a DBS check. Notices were displayed throughout the practice advising patients that chaperones were available if required. Patients spoken with were aware of this service provided.
- There was an effective system to manage infection prevention and control. Staff had access to policies and procedures and a designated infection prevention and control (IPC) clinical lead. Discussions held with the lead clearly demonstrated they were aware of their roles and responsibilities. The most recent IPC audit had been

carried out in September 2017 and the outcome had been shared with external cleaners responsible for maintaining the cleanliness of the practice. An action plan had been developed to address the improvements identified. However, actions that had been completed had not been documented.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. The practice were evolving their workforce and had employed an additional GP and an advanced nurse practitioner (ANP), who was also an independent prescriber, to help meet the health and social needs of their patients and the demands on the practice. In addition the practice was looking to provide a more diverse skill mix to include a physician associate. Clinical work was covered within the team and non-clinical staff covered each other and had actively sought to develop deputies for key roles to encourage multi-tasking.
- There was an effective induction system for staff tailored to their role. For example, we saw checklists in place for locum staff that included checks made against their registration status, qualifications and training records. A comprehensive induction pack was also available.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. We saw sepsis decision tools were displayed on walls and were accessible on the practice clinical system to support clinicians in their practice. Receptionists also had clear 'red flag' sepsis guidance to help identify patients in need of immediate treatment.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The practice used the Map of Medicine to facilitate referrals along accepted pathways. This provided comprehensive, evidenced based local guidance and clinical decision support at the point of care and was effective in reducing referrals.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines.

1. The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice were aware of the risks associated with decisions regarding emergency medicines held at the practice and in GP bags on home visits. However, we saw that not all of the suggested emergency medicines were held at the practice or carried in GP bags on home visits. A basic risk assessment had been completed but lacked detail to clearly demonstrate how risks to patients would be mitigated in the absence of all of the suggested list of emergency medicines. For example, the absence of the medicine naloxone (a medicine used to block or reverse the effects of opioid medication). We were advised that all home visit requests were triaged by a GP and a clinical decision was made regarding the most appropriate course of intervention. Following the inspection the practice sent us supporting evidence that they had since assessed the risk of not carrying or stocking all of the suggested medicines and had taken into account their location, services provided and the patient population. During the inspection we saw multiple cylinders of oxygen that were not kept in a secure area.
- The practice kept prescription stationery securely as previously recommended and monitored its use. However, the monitoring of uncollected prescriptions was not effectively managed as we found several prescriptions dated September and October 2017 that

- had not been collected and there was no evidence of action taken. Following the inspection the practice advised us they would discuss this with the customer care lead and review and amend their current protocol.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing and worked closely with the Clinical Commissioning Group medicines optimisation team. They had registered as antibiotic guardians pledging to safeguard antibiotics for the future and were currently benchmarked as CCG average for prescribing antibiotics.
 - Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were risk assessments in relation to safety issues in place and records of routine safety checks undertaken.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and procedure for recording and acting on significant events and incidents. The policy and recording form was due to be updated by the new interim practice manager to provide clearer sections on the form for detailing the actions taken and a review date. Staff we spoke with understood their duty to raise concerns and report incidents and near misses. They told us they were encouraged to raise concerns and report incidents and near misses and demonstrated an understanding of the procedure.
- There were systems for reviewing and investigating when things went wrong. The practice had recorded 36 significant events in the last 12 months and discussed these at significant event meetings held and had investigated them. We saw events were recorded but not always in chronological order many did not always demonstrate a clear audit trail. Not all of the staff we

Are services safe?

spoke with were able to share an example of a recent significant event and the action taken to improve the quality of patient care from the lessons learnt as previously recommended. A regular analysis of events had not been undertaken to identify common trends. A member of staff shared an example of a significant event they had raised after administering an out of date vaccine. The patient affected was contacted and provided with a full assessment. Advice was sought from external agencies and procedures were reviewed and improved.

- The practice told us that following advice provided by the NHS England 'Supporting Change in General Practice' team they had developed a new system for logging external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety. Following an alert being received, the practice maintained a central spreadsheet detailing the action taken to ensure that patients were not affected by the medicines or equipment involved.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services and good across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice was comparable to the Clinical Commissioning Group (CCG) and national averages for antibiotic prescribing. Data provided by the practice for January to December 2016 showed the practice's overall antibiotic prescribing rate was 1.27 items, 9% above the CCG benchmark of 1.16 items. The practice was aiming to reduce overall antibiotic prescribing and had signed up as Antibiotic Guardians, a campaign led by Public Health England (PHE) that urges members of the public and healthcare professionals to take action in helping slow antibiotic resistance. The practice were working with the CCG medicines optimisation team in appropriate antibiotic prescribing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice held a register and had identified 639 patients over the age of 65 who were frail. They were aiming to carry out holistic assessments of between 220 to 240 of these patients within the period April 2017 and April 2018 and develop a care plan with them in conjunction with the nurse and GP and review their medication.
- The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Patients over the age of 75 years had a named GP and were offered health checks.

People with long-term conditions:

- The practice offered a number of clinics for patients with long-term conditions. Patients had a structured annual review to check their health and medicines needs were being met. Patients with asthma, diabetes and chronic obstructive pulmonary disease (lung diseases) were provided with a management plan developed in partnership with them.
- For patients with the most complex needs, GPs worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- 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 for 2016/17 showed 94% of patients with diabetes had a blood pressure reading (measured in the preceding 12 months) within recognised limits. This was comparable to the clinical commissioning group and national averages of 92%. Their exception reporting rate of 7% was higher than the CCG average of 4% and national average of 5%. Exception reporting is the removal of patients from QOF calculations where, for example, patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.
- Eighty-four per cent of patients with asthma had received an asthma review in the preceding 12 months that included an assessment of asthma control. This was higher than the CCG average of 79% and the national average of 77%. However, their exception reporting rate of 19% was higher than the CCG average of 6% and the national average of 8% meaning fewer patients had been included.

Families, children and young people:

- Contraception services were offered including implants and intrauterine contraceptive devices (coils).
- Child immunisations were offered by the practice and carried out in line with the national childhood vaccination programme. Patients who missed any of their immunisations were monitored and recalled.

Are services effective?

(for example, treatment is effective)

Uptake rates for the vaccines given to under two year olds were above the target percentage of 90%. The uptake rates for vaccines given to five year olds ranged from 68% to 97%.

- Routine antenatal clinics were available with the visiting midwifery team in addition to a drop-in mother and baby clinics for advice and weight monitoring.
- Same day appointments were available for acutely unwell young patients.

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

- The practice's uptake for cervical screening was 77%, which was comparable with the clinical commissioning group average of 79% and the national average of 81%. The practice exception reporting of 13% was above the CCG average of 6% and the national average of 7%.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. Data provided by the practice showed they had completed 75 of these health checks for the period 2016/17 and 85 so far from April 2017. The practice told us they had increased the hours of a health care assistant to improve the uptake.
- Telephone consultations were utilised where appropriate and the practice was exploring the use of online/skype consultations.
- The practice allowed the temporary registration of students home for holidays.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had 46 registered patients with a learning disability. Twenty two of these patients had received an annual review.
- The practice were monitoring discharge letters from A&E and hospital wards to identify any patients whose condition may indicate that an early GP or nurse review should be offered.
- The practice had identified (0.41%) of the patient list as carers and signposted them to local services offering support and guidance.

People experiencing poor mental health (including people with dementia):

- The practice held a register of patients experiencing poor mental health and carried out health reviews which included general health checks and health promotion. The practice exception reporting rate of 12% was higher than the CCG average of 10% and comparable to the national average of 13%.
- 79% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months compared with the CCG and the national averages of 84%. The practice exception reporting rate of 3% was lower than the CCG average of 6% and the national average of 7%.
- Patients over the age of 75 were offered health checks with GP intervention for any concerns of mental health and dementia.

Monitoring care and treatment

The practice was actively involved in quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. A range of clinical audits were planned and undertaken throughout the year and linked to National Institute for Health and Care Excellence (NICE) best practice guidelines. Findings were presented at monthly clinical meetings held. As an example, the practice had conducted an audit on adult patients with type two diabetes on regular antiplatelet therapy within a set criteria to ensure they were being given this appropriately to ensure that NICE best practice guidelines were followed and implemented. Patients identified as not requiring this were invited to discuss this face to face or on the telephone.

Other quality improvement activity included call monitoring. The practice had appointed a designated customer care lead who conducted monthly analysis of the telephone system following complaints in relation to access. A visual call monitoring system was in place that identified the number of calls received, answered, missed, outgoing calls and calls waiting. Data collected was logged and analysed. Calls were monitored to improve quality and staff outcomes were recorded. Any area identified as requiring improvement was actioned with the staff member concerned to help improve patient experience.

Are services effective?

(for example, treatment is effective)

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The most recent published results for 2016/17 showed the practice had achieved 96% of the total number of points available compared with the clinical commissioning group (CCG) and the national averages of 95%. The practice clinical exception rate of 13% was above the CCG average of 9% and the national average of 10%. Clinical exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable or decline to attend a review meeting or certain medicines cannot be prescribed because of side effects. The practice had a designated member of staff responsible for reviewing and presenting data at monthly meetings held for discussion and action planning.

We saw that the exception rates for a number of clinical domains (to include mental health and diabetes) were higher than the CCG and national average. We explored this during and after the inspection and were advised that the system used for exception reporting had been reviewed and was now being left to later in the cycle and patients were being encouraged to attend for review. However, the practice told us that some patients had expressly refused to engage with clinicians despite repeated encouragement and advice to do so in addition to the practice area having high levels of deprivation. Following the inspection the practice conducted a search on the exception reporting in the three chronic diseases (chronic obstructive pulmonary disease, mental health and diabetes) in which they had identified as outliers. The results shared with us demonstrated a decrease in current exception reporting from the previous year 2016- 2017 and the practice told us they were working to further reduce the need to record exception codes.

Effective staffing

The practice had a well-established team of staff who had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff which were assessed as part of their induction and annual appraisal. We saw staff were provided with protected time and training opportunities for personal

development. Newly appointed staff received an induction to their work which included essential training in safe working practices and equality and diversity. Records of staff skills, qualifications and training were maintained.

- Staff were encouraged and given opportunities to develop. For example a former receptionist had been appointed as a customer care lead and a nurse had recently completed the Warwick diploma in diabetes care to equip them with the skills and knowledge needed to provide high quality of care to their patients.
- The practice provided staff with ongoing support. This included an induction process, informal discussions, appraisals, tutorials, clinical supervision, daily mid-morning clinical meetings for case discussions; prompt trouble shooting, supportive conversations, prescription signing and discussions in relation to home visit requests. Support was also available for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies. A representative of the practice attended integrated local care team meetings . These meetings comprise of nursing and adult social care teams who support frail, older people and those living with long term conditions such as asthma and diabetes, heart failure, providing care before a crisis occurs. The teams work together to identify those in greatest need of health and social care services enabling the provision of co-ordinated, timely care.

Are services effective?

(for example, treatment is effective)

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included frail patients, patients in the last 12 months of their lives, vulnerable patients, those at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. For example, patients with long term conditions and frail patients who were provided with a management care plan to help monitor their symptoms and condition and referral to other agencies such as occupational therapy, physiotherapy and audiology.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health and supported and signposted patients that required support.

- The practice provided a smoking cessation advisory service in addition to a weight management programme.
- NHS health checks were offered in addition to chlamydia screening for 16 to 24 year olds.
- The practice was effective in referring patients with possible cancer. Data from Public Health England showed that 63% of new cancer cases (among patients registered at the practice) were referred using the urgent two week wait referral pathway. This was higher than the CCG average of 55% and the national average of 50%.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- Clinicians were able to share examples of how and what procedures they obtained consent for. For example, written consent was obtained for minor surgery.

Are services caring?

Our findings

We rated the practice as good for caring and good across all population groups.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs and had received training and had access to a policy on equality and diversity.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a quiet room to discuss their needs in private.
- Sixteen of the 22 patient Care Quality Commission comment cards we received were complimentary about the service experienced. Five were mixed and one was negative. Patients described staff as very welcoming, helpful, flexible, understanding, polite and respectful. One patient told us there was a lack of rapport.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Two hundred and ninety two surveys were sent out and 113 were completed giving a return rate of 39%. Patient satisfaction scores for consultations with GPs were mainly in line with the Clinical Commissioning Group (CCG) and national averages but mostly lower for nurse consultations. For example:

- 86% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 82% of patients who responded said the GP gave them enough time; compared with the clinical commissioning group (CCG) and the national averages of 86%.
- 91% of patients who responded said they had confidence and trust in the last GP they saw; compared with the clinical commissioning group (CCG) and the national averages of 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.

- 92% of patients who responded said the nurse was good at listening to them; compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 84% of patients who responded said the nurse gave them enough time; compared with the clinical commissioning group (CCG) and the national averages of 92%.
- 93% of patients who responded said they had confidence and trust in the last nurse they saw; compared to the clinical commissioning group (CCG) and the national averages of 97%.
- 84% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; compared with the clinical commissioning group (CCG) and the national averages of 91%.
- 59% of patients who responded said they found the receptionists at the practice helpful. This was significantly lower than the clinical commissioning group (CCG) average of 86% and the national average of 87%.

The results of the survey had been shared with the patient participation group and a summary was displayed behind the reception. To improve the quality of calls the practice had developed and implemented a set of quality of call standards which enabled calls to be monitored for training and learning purposes and improve customer care.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care. Interpretation services were available for patients who did not have English as a first language. A self-check in facility was also available in a variety of languages in addition to a hearing loop for patients with a hearing difficulty. Cancer screening information leaflets were also available in Polish and Urdu.

Staff helped patients to be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given). Staff helped patients and their carers find further information and access community and advocacy services.

The practice identified patients who were carers. The practice's computer system alerted GPs and staff if a patient was also a carer. The practice had identified 42

Are services caring?

(0.41%) of the patient list as carers and were actively trying to identify carers on their website. We saw information and contact details were displayed in the waiting area and carers were signposted to services offering support and guidance to include the local voluntary carers association. Carers were offered an annual flu vaccine and health check.

Bereaved patients were provided with advice on how access bereavement support services or local counselling services such as the Dove Centre. Various information leaflets and helpful guides for the bereaved were readily available.

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 mainly in line with local and national averages:

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) average of 87% and the national average of 82%.

- 91% of patients who responded said the last nurse they saw was good at explaining tests and treatments; compared with the clinical commissioning group (CCG) average of 91% and the national average of 90%.
- 85% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; compared with the clinical commissioning group (CCG) average of 87% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of maintaining patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Chairs in the waiting room were positioned away from the reception desk to promote confidentiality.
- A quiet room was available should a patient wish to discuss sensitive issues or breast feed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice as requires improvement for providing responsive services and good across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example by providing extended opening hours and online services such as repeat prescription requests, booking appointments and access to medical records. The electronic prescribing service had also been introduced since the last inspection. The practice had also altered the appointment system, creating more same day appointments and created more incoming telephone lines and internal reallocation of administrative staff to receive telephone calls during busy periods.
- The practice had reviewed and increased its workforce and employed an additional GP and advanced nursing practitioner. Staffing hours had been increased to help meet the health and social needs of patients and the demand for the service. The practice were looking to provide a more diverse skill mix to include a physician associate and a clinical pharmacist.
- The practice improved services where possible in response to unmet needs. For example, the practice had started a clinic for vulnerable adults for example patients who were homeless, alcohol or substance dependent.
- The facilities and premises were appropriate for the services delivered. Following the last inspection the reception area had been revamped to include a lowered desk providing greater access for patients using a wheelchair. A breastfeeding room had also been created.
- The practice provided around 1,500 home visits each year for patients that were unable to attend the practice.
- The practice made reasonable adjustments when patients found it hard to access services. For example, telephone consultations were available with a GP.

- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice used the frailty index to identify health risks to this population group.
- The practice provided in-house fitting of ring pessaries.
- Health checks were available for patients aged 65 and over.

People with long-term conditions:

- The practice provided a number of long term condition clinics in order to support patients to manage these conditions, monitor their wellbeing and develop management plans in conjunction with them.
- Patients with a long-term condition were identified and received a structured holistic review to check their health and medicines needs were being appropriately met. Generous annual review appointment times were provided and patients with diabetes, asthma & COPD were provided with self-management plans.
- The practice held regular meetings with the Integrated Local Care Team (ILCT), a team that included health and social care professionals, to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- The practice had systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Appointments were offered outside school hours for school aged patients and children were seen on the same day. Acutely unwell children were always seen by a GP.
- Weekly antenatal clinics were held with the midwife at the practice.
- Contraception advice and services were offered including implants and intrauterine contraceptive devices (coils).

Are services responsive to people's needs?

(for example, to feedback?)

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours appointments were offered Tuesday evenings in order to offer flexibility for patients and the practice allowed the temporary registration of students home for holidays.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours in addition to online services for booking of appointments and repeat ordering of medication.
- NHS Health Checks were provided for patients aged 40 to 74 and patients were given lifestyle advice on exercise and diet.
- The practice was exploring the use of online/skype consultations
- The practice held a mental health register and provided patients with a care plan and a structured annual review which included general health checks and health promotion.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. A clinic was in place for review of dependency needs and complex issues and family support for those indirectly affected by drug and alcohol dependency issues.
- There was ongoing work to obtain carers' contact details for patients experiencing poor mental health.
- There was proactive timely diagnosis of dementia and referral to the appropriate specialist clinic.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and offered longer appointments for patients with complex needs or for patients requiring extra time and care.
- Last appointments were made available upon request to provide a calmer environment and reduce distress for patients.
- Staff had received Olive Branch Training which helps target people who are in contact with, or visit vulnerable members of the local community. It encourages them to identify potential fire hazards and other risks in the home and reduce the number of accidental fires and deaths. In addition it highlights how to refer vulnerable people onto the fire and rescue service for a free home fire risk check.
- The practice was registered on the safe place scheme providing a safe temporary place for a person with a learning disability or dementia to go if they felt distressed or vulnerable. People on the scheme are provided with a Keep Safe card, which includes name and contact numbers of relatives and friends who can be called on for help.

People experiencing poor mental health (including people with dementia):

- Patients had access to initial assessment, test results, diagnosis and treatment.
- Patients had experienced difficulties making an appointment and this was identified at the last inspection and the previous year's national GP survey. However, patients we spoke with during the inspection told us access to appointments was beginning to improve and this was also evidenced in the majority of the completed CQC comment cards we received.
- Patients with the most urgent needs had their care and treatment prioritised, for example acutely unwell children.

Results from the national GP patient survey published in July 2017 showed that patients' satisfaction with how they could access care and treatment was significantly lower than the local and national averages, especially for telephone access, experience of making an appointment and wait times. For example:

- 61% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 21% of patients who responded said they could get through easily to the practice by phone; compared with the clinical commissioning group (CCG) average of 67%

Are services responsive to people's needs?

(for example, to feedback?)

and the national average of 71%. At our previous inspection the GP patient survey results for 2014 showed 54% of patients who responded said they could get through easily to the practice by phone.

- 67% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; compared with the clinical commissioning group (CCG) average of 83% and the national average of 84%.
- 55% of patients who responded said their last appointment was convenient; compared with the clinical commissioning group (CCG) and the national average of 81%.
- 38% of patients who responded described their experience of making an appointment as good; compared with the clinical commissioning group (CCG) and the national averages of 73%.
- 52% of patients who responded said they don't normally have to wait too long to be seen; compared with the clinical commissioning group (CCG) and the national averages of 58%.

The practice acknowledged results in relation to access prior to the patient survey, which was reported in July 2017, had been poor. As a result they had taken action to respond to the feedback received through the patient survey and complaints received. The practice was proactively working to improve access to appointments. The practice told us they offered over 900 appointments per week and over 1,000 appointments per year were lost because patients failed to attend and therefore this may reduce the availability of appointments for other patients. The practice told us they would continue to evaluate their appointment availability and would be looking to recruit additional practitioners when one of their GPs reduced their workload.

As a result of patient feedback they had displayed a 'You said we did' notice close to the self-check in area, which identified the main concerns about access to the service. The practice had made changes to the telephone and appointment system. Notices were displayed in the waiting area advising patients that as from 6 November 2017 all

morning appointments were only bookable on the day from 8am. The practice had increased the telephone lines available and introduced a dedicated line for prescriptions only. Administrative staff had been reallocated to receive telephone calls during peak periods. A visual call monitoring system had been installed and was fully operational from July 2017. This identified the number of calls received, answered, missed, outgoing calls and calls waiting. Data collected was logged and analysed on a monthly basis. We saw the number of calls answered had improved. An additional GP and an advanced nurse practitioner had also been employed to help meet demand. A patient survey had very recently been developed seeking patients' views on the new appointment system.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them to continually improve the quality of care.

- Information about how to make a complaint or raise concerns was available on the practice website but not readily accessible in the practice. All of the patients we spoke with were not aware of how to make a complaint. However, following our feedback complaint information leaflets were made available at reception. There was a box in the reception area for patients to leave their comments.
- The practice manager was the designated lead for managing complaints. The complaint policy and procedures were in line with recognised guidance. We saw eight complaints had been recorded in the last 12 months with the common theme being access to appointments which had led to a change in the appointment system. Complaints were shared with the patient participation group (PPG). We reviewed the complaints received and found complaints were satisfactorily handled but two complaints had delayed responses and the action taken was not well documented possibly due to changes experienced in practice management.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service and good across all population groups.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services and understood the challenges and were addressing them. For example, they had reviewed the appointment system and increased their workforce to include the appointment of a new GP partner and an advanced nurse practitioner who was an independent prescriber to meet patient demand and expectations.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff had lead roles and were aware of their roles and responsibilities. Nursing staff and administration staff spoke highly of the support provided by the partners.
- The practice was involved in the education and assessment of medical students and GP registrars and wished to be considered as a centre involved in the training of primary care nurses.
- The practice had effective processes to develop leadership capacity and skills, including further workforce planning for the future of the practice.
- The partners were aware of their strengths and areas for improvement.

Vision and strategy

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

- The practice had a mission statement in addition to a clear vision and set of values. Their ethos was to work beyond traditions and they strongly believed in involving and empowering patients in their care to provide the highest standard of holistic health and medical care and advice within available resources.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

- The practice planned its services to meet the needs of the practice population. For example, the practice were continuing to review its staff skill mix to meet patient expectations and demand. They had been successful in securing a bid for the future employment of an in-house pharmacist to help undertake medicine reviews. As part of their future vision they were looking to recruit a physician associate in addition to a paramedic to assist with their high level of home visits including the services provided to seven local residential and nursing homes.

Culture

The practice had a culture of high-quality sustainable care.

- The practice demonstrated a culture of caring for patients and staff and providing culturally sensitive medical care.
- Staff we spoke with told us they felt respected, supported and valued and enjoyed working in the practice.
- The practice focused on the needs of patients and had introduced changes as a result of patient feedback. For example, a new telephone system and changes to the appointment system.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. We saw that patients received an apology where appropriate.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed and had access to a policy in the event of needing to raise concerns in relation to staff practice in the workplace and would be supported with the process.
- There were processes for providing staff with the development they need. This included appraisal and career development conversations. Staff had received an annual appraisal in the last year and were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for attending various meetings held in addition to professional development and evaluation of their clinical work.

Are services well-led?

Good 

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

- The practice actively promoted equality and diversity and staff had received training. Staff felt they were treated equally and reported there were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. Clinical staff held lead roles in dedicated areas. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of health and safety, safeguarding and infection prevention and control.
- We saw there were a range of policies and procedures in place however, we saw a number of these were not dated, signed and were not readily accessible.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. We saw staff also had access to an employee safety handbook and an independent company provided support in relation to health and safety management.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through ensuring they only worked within their competence and discussions of their consultations and prescribing and referral decisions.
- Practice leaders had oversight of incidents, and complaints in addition to external alerts, such as the Medicines and Healthcare products Regulatory Agency (MHRA) alerts that may affect patient safety.
- Clinical audit had a positive impact on quality of care and outcomes for patients.
- The practice had plans in place for major incidents.

- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.
- The practice acknowledged that results in relation to access continued to be poor and had taken action to respond to the feedback received through the patient survey and complaints received. They were closely monitoring performance on a monthly basis.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where staff had sufficient access to information.
- The practice submitted data or notifications to external organisations as required.
- The practice used information technology systems to monitor and improve the quality of care. For example, the practice was undertaking skype medicine review consultations for stable patients residing in local residential and nursing homes.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Staff we spoke with had a clear understanding of their responsibility safeguarding data.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG) that consisted of five core members and the practice were trying to increase membership to ensure the whole patient population were represented. The PPG usually met quarterly and meetings were chaired by a member of the PPG. We spoke with the PPG chair and they told

Are services well-led?

Good 

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us the group were actively involved and felt valued and included in the development of practice. They said leaders were open to suggestions for improvement. For example, they were involved in registering the practice as a Safe place (provision of a temporary safe place for vulnerable people), training for this and improving the signage to the building. They were also involved with improving patient access and organising events to include an autumn fayre, recent Macmillan coffee morning, a raffle and food hampers.

- The service was transparent, collaborative and open with stakeholders about performance.
- The practice acknowledged the challenges they had meeting the demands of their patient population and had introduced changes to improve patients' experiences of accessing appointments. Access to the practice by telephone was being monitored on a monthly basis and the practice was carrying out their own in-house survey to gain patient views about access to the practice.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice.
- The partners met regularly to take the work forward and to strengthen and support each other and ensure future sustainability. The practice had a five year business plan in place which included employing additional clinicians with a diverse skill mix to help meet the needs, expectations and demands of the practice population.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice took part in schemes and provided staff with training to include the Olive Branch project and the Safe Place scheme helping vulnerable patients and members of the local community.
- The practice was a training practice and currently had three GP registrars and a final year medical student. In the future they wished to be considered as a centre involved in the training of primary care nurses.