North Ridge Medical Practice

Quality Report

North Ridge
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Date of inspection visit: 23 November 2017
Date of publication: 29/01/2018

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection July 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

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 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.

At this inspection we found:

- There was an open and transparent approach to safety and a system for reporting and recording significant events.
- The practice had clearly defined and embedded systems to help minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- The practice monitored outcomes for patients via a programme of audits that were used to make improvements to patient care.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

Summary of findings

- Patients we spoke with 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 facilities were limited by their listed building status but staff made adaptations and the practice 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. There was an active and highly engaged patient participation group (PPG).
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The area where the provider should make improvement is:

- Continue to work towards moving to new premises in order to address the current issues with suitability of buildings and access arrangements.
- Consider providing a hearing loop in the practice to assist patients with hearing impairment.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

The six population groups and what we found

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

Older people	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

North Ridge Medical Practice

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 North Ridge Medical Practice

North Ridge Medical Practice is situated in Hawkhurst, Kent. The practice is aligned to the NHS West Kent Clinical Commissioning Group (CCG) and has a general medical services contract with NHS England for delivering primary care services to the local community.

The practice has a patient population of 5,501. The proportion of patients who are aged 0 to 10 years, and 20 to 45 years is lower than the national average and the proportion of female patients aged 10 to 19 years is significantly higher than the national average. This is because the practice is the registered practice for the population of a local girls' boarding school. The practice is in an area with a lower than average deprivation score, and lower than average levels of unemployment.

The practice is located in a listed building in the High Street. There is limited patient parking available at the practice, although there are public car parks nearby.

There are three GP partners, two male and one female. These GPs are supported by a regular locum GP (female) who is directly employed by the practice. There is one advanced nurse practitioner, two practice nurses and two health care assistants (all female). In addition, there is a business manager and a practice manager as well as a team of reception and administrative staff.

The practice is a dispensing practice and employs four dispensers. The practice dispenses to approximately 60% of the patients on its list.

The practice is not a teaching or training practice (teaching practices take medical students and training practices have GP trainees and doctors undertaking a two-year training programme following graduation from medical school).

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are offered from 7.30am to 8am and 6.30pm to 7.30pm on Tuesday. The practice's telephone lines are closed between 1pm and 1.30pm daily. Patients who need to contact the practice urgently during this time are given an alternative telephone number to call and speak with a member of staff.

Primary medical services are available to patients via an appointments system. There is a range of clinics for all age groups as well as the availability of specialist nursing treatment and support. 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: North Ridge, Rye Road, Hawkhurst, Cranbrook, Kent, TN18 4EX.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of eighteen documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written or face to face apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events. We saw from the minutes of meetings that significant events were discussed among relevant staff.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, additional identity checks were introduced by dispensary staff when handing out medicines following an incident where a patient was incorrectly given medication meant for a patient who had the same name.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.

- Arrangements for safeguarding 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. One of the GPs was the lead member of staff for safeguarding and the practice manager was the deputy. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses had received safeguarding training to level two.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems to help ensure that standards of cleanliness were maintained.
- One of the practice nurses was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken where possible to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to help ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to help ensure prescribing was in line with best practice

guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training, and undertook continuing learning and development.
- Records showed that all members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly by the lead GP for the dispensary.
- Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw evidence of regular review of these procedures in response to incidents or changes to guidance in addition to annual review.
- Dispensary staff identified when a medicine review was due and told us that they would alert the relevant GP to reauthorise the medicine before a prescription could be issued. This process helped ensure patients only received medicines that remained necessary for their conditions
- A bar code scanner was in use to check the dispensing process and dispensary staff described the process that ensured second checks by another staff member or doctor when dispensing certain medicines, for example controlled drugs, took place.
- We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged and then reviewed promptly using the same process as for other significant events. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.
- There were systems to deal with any medicines alerts or recalls, and records were kept of any actions taken.
- Records showed medicine refrigerator temperature checks were carried out which helped ensure medicines were stored at the appropriate temperature and staff were aware of the procedure to follow in the event of a fridge failure.
- 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. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. There were arrangements for the safe destruction of controlled drugs.

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a comprehensive range of other risk assessments to monitor safety of the premises such as control of substances hazardous to health, 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. There was a rota system to help ensure enough staff were on duty to meet the needs of patients.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the emergency 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

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.
- 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:

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- The practice discussed elderly vulnerable patients at a monthly meeting with district nurses, social workers and members of the local hospice team.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long-term conditions:

- Nursing staff had lead roles in long-term disease management, such as diabetes, and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes whose last blood pressure reading was 140/80 mmHg or less was 82%, compared to the Clinical Commissioning Group (CCG) average of 77% and the national average of 78%.
- The percentage of patients with diabetes whose last measured total cholesterol was 5 mmol/l or less was 82% compared to the CCG average of 82% and the national average of 80%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health. Information was shared with the practice's out of hours care provider.

Families, children and young people:

- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and adaptations to the premises were made for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- One of the GP partners was the medical officer to a large local boarding school. They offered three clinics per week at the school and also provided weekend cover. They attended regular meetings with the school nurses and referred patients to the school counselling service if required. The GP had a particular interest in mental health issues affecting this population group.

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

- The needs of these populations 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 and telephone appointments.
- 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

Are services effective?

(for example, treatment is effective)

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 offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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 carried out advance care planning for patients living with dementia.
- The percentage of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months was 86%, which is comparable to the Clinical Commissioning Group (CCG) and national average of 84%.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan was 100%, which was higher than the CCG average of 92% and the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could 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.

Monitoring care and treatment

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%.

Exception rates were low (3%) compared to the CCG and national averages (6%). (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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages.
  - The percentage of patients with diabetes whose last blood pressure reading was 140/80 mmHg or less was 82%, compared to the CCG average of 77% and the national average of 78%.
  - The percentage of patients with diabetes whose last measured total cholesterol was 5 mmol/l or less was 82% compared to the CCG average of 82% and the national average of 80%.
- Performance for mental health related indicators was similar to or higher than the CCG and national averages.
  - The percentage of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months was 86%, which is comparable to the CCG and national average of 84%.
  - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan was 100%, which was higher than the CCG average of 92% and the national average of 89%.

There was evidence of quality improvement including clinical audit:

- The practice showed us a comprehensive audit record that included fifteen audits that had been undertaken in

Good

Are services effective?

(for example, treatment is effective)

the previous twelve months. We saw detailed evidence of four comprehensive, completed audits where the improvements made were implemented and monitored.

- Findings were used by the practice to improve services. For example, recent action taken as a result included ensuring that all patients who required antipsychotic medicines (medicines used to treat psychosis, which can also affect the heart rhythm) were screened for cardiac irregularities before medicines were prescribed.

Information about patients' outcomes was used to make improvements. The practice produced regular dashboards showing outcomes for patients with diabetes, chronic obstructive pulmonary disease (COPD), and for patients taking anticoagulant medicines (used to help prevent blood clots). These showed that the practice had improved outcomes for patients with these long term conditions over the six months to November 2017. For example, 24% of patients with diabetes met all clinical targets in November 2017, compared to 17% in May 2017.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety as well as confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. One of the practice nurses was trained to carry out spirometry, a test to determine lung capacity, for patients with chronic obstructive pulmonary disease (COPD).
- 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, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation as well as support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating care and treatment

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

- This included care and risk assessments, care plans, medical records and investigation and test results. We saw evidence of comprehensive care planning for patients with mental health issues, including dementia.
- 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. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

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

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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, alcohol consumption and smoking cessation.

Good

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 83% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 69% to 90% and five year olds from 81% to 92%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. Staff took opportunities, for example when patients attended influenza vaccination clinics, to help ensure that uptake of screening was high. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. 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.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains, or separate examination rooms, were provided in consulting rooms to help maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations. Background music was played in the waiting area so that conversations taking place in consultation rooms could not be overheard.
- Reception staff told us that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the thirty-four 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.

We spoke with seven patients including two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments 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 comparable with the local clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% of respondents said the GP was good at listening to them compared with the CCG average of 90% and the national average of 89%.
- 87% of respondents said the GP gave them enough time compared to the CCG average of 88% and the national average of 86%.
- 97% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 86% of respondents said the last GP they spoke with was good at treating them with care and concern compared to the CCG average of 87% and the national average of 86%.
- 93% of respondents 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%.
- 94% of respondents said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 99% of respondents said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 91% of respondents said the last nurse they spoke with was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 93% of respondents said they found the receptionists at the practice helpful compared with the CCG average of 89% and the national average of 87%.

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 saw comprehensive care plans, for example for patients with mental health issues, including dementia that showed how individuals and their families were involved in their care. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

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

Good

Are services caring?

- 91% of respondents said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 86%.
- 86% 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%.
- 89% of respondents said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 87% of respondents said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

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

- Staff told us that interpretation 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. Staff had cards in a variety of languages to help patients with registration and other queries.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its patient population:

- The practice offered extended hours on a Tuesday morning from 7.30am and in the evening until 7.30pm.
- There were longer appointments of up to 30 minutes 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.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- One of the GP partners was the medical officer to a large local boarding school. They offered three clinics per week at the school and also provided weekend cover. They attended regular meetings with the school nurses and referred patients to the school counselling service if required. The GP had a particular interest in mental health issues affecting this patient population group.
- Access to the building for people with mobility issues and those with prams/pushchairs was via temporary ramps. Patients were encouraged to inform reception if they needed ramps to access the building. There was one consulting room that could be accessed from the waiting room without using stairs. Staff told us that they used this room for patients with mobility issues. Other consultation rooms were down three steps from the waiting area. Staff told us that they assisted patients in and out of their consultations as required.
- The practice did not have a hearing loop.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- 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 and Saturday dispensary opening hours.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to the service

The practice was open between 8am and 6.30pm Monday to Friday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. Pre-bookable appointments were from 8.35am to 10.35am and 4.20pm to 6pm daily. Urgent same-day appointments were available between 10.55am and 11.55am daily. Extended hours appointments were offered from 7.30am to 8am and 6pm to 7.30pm every Tuesday. The practice's telephone lines were closed between 1pm and 1.30pm daily. Patients who needed to contact the practice urgently during this time were given an alternative telephone number to call and speak with a member of staff.

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

- 78% of respondents were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 73% of respondents said they could get through easily to the practice by telephone compared to the CCG average of 74% and the national average of 71%.
- 89% of respondents said that the last time they wanted to speak with a GP or nurse they were able to get an appointment compared with the CCG average of 88% and the national average of 84%.
- 86% of respondents said their last appointment was convenient compared with the CCG average of 85% and the national average of 81%.
- 84% of respondents described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 59% of respondents said they didn't normally have to wait too long to be seen compared with the CCG average of 58% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. Patients specifically noted that the introduction of on-line appointment booking had improved access.

The practice had a system to assess:

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

Patients requesting a home visit received a telephone call from one of the GPs to assess their needs. 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.

- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, there was a notice in the waiting area and there was information on the practice's website.
- The practice's complaints policy did not include information for patients about outside agencies to refer to if they were not satisfied with the practice's response to their complaint. We discussed this with the practice and they sent us evidence that this had been included in a policy update within a short time of our visit, bringing the practice's policy and procedures in line with recognised guidance and contractual obligations for GPs in England.

We looked at four complaints received in the last 12 months and found that they were satisfactorily handled and dealt with in a timely way. The practice was open and transparent when dealing with complaints. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

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.

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. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- The practice had a strong culture of caring and continuous improvement and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- 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.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff 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 professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- 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.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. One of the GPs was the lead for clinical governance. Other GPs and nurses had lead roles in key areas.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. There were comprehensive risk assessments that were updated and reviewed regularly.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Are services well-led?

Good

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff 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.

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 all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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. An annual survey of staff views was undertaken by the practice.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.

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 practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. One of the partners represented the practice at the local clinical commissioning group (CCG) cluster meetings.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.