

Kingsway Health Centre

Inspection report

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Date of inspection visit: 04/07/2018
Date of publication: 10/08/2018

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 location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



Overall summary

This practice is rated as Requires Improvement overall. (Previous rating; inspected July 2017, published September 2017 – Requires Improvement)

The key questions at this inspection are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? – Good

We undertook a comprehensive inspection of Kingsway Health Centre on 20 July 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement for providing caring and responsive services. The full comprehensive report on the July 2017 inspection can be found by selecting the 'all reports' link for Kingsway Health Centre on our website at .

This inspection was an announced comprehensive inspection carried out on 4 July 2018 to confirm that the practice had carried out the required improvements that we identified during our previous inspection on 20 July 2017. Overall the practice is now rated as good.

At this inspection we found:

- The practice had clear 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.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Data from the national GP patient survey, published July 2017, showed patients rated the practice lower than others for all aspects of care and with how they could access care and treatment. We saw evidence of the practice's ongoing efforts to improve patient

satisfaction, including investment in new technologies to improve access. Comments cards received from patients reflected on improvements within the service over time.

- All patients we spoke with had been able to access care when they needed it.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- 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 a strong focus on continuous learning and improvement at all levels of the organisation.

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

- Ensure care and treatment is provided in a safe way to patients.

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

- Continue to review and consolidate staff immunity records to ensure that the practice is operating in accordance with Public Health England guidance.
- Continue to monitor the management of pathology results to ensure that all results are reviewed by a clinician in a timely manner.
- Ensure that staff are provided with clear guidance and training when assigned new roles and that review is undertaken routinely to ensure newly assigned responsibilities are being fulfilled.
- Continue monitoring patient satisfaction and efforts to improve patient satisfaction with the service.
- Continue with efforts to identify and support carers.
- Continue to engage with eligible patients to improve uptake of cervical and bowel screening.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a

GP specialist adviser, a practice manager adviser and a second CQC inspector. The team was also supported by an interpreter to support interviews with patients conversant in Urdu.

Background to Kingsway Health Centre

Kingsway Health Centre provides a range of primary medical services, including minor surgical procedures, from its location at Kingsway Health Centre, 385 Dunstable Road, Luton, Bedfordshire, LU4 8BY. It is part of the NHS Luton Clinical Commissioning Group (CCG). The practice holds an Alternative Provider Medical Services (APMS) contract for providing services, which is a nationally agreed contract between general practices and NHS England for delivering general medical services to local communities. The registered provider is Phoenix Primary Care Limited who have merged with The Practice Group a company that provides services on behalf of the NHS.



The practice serves a population of approximately 9,000 patients with higher than national average populations of patients aged under 18 years and lower than national average populations of patients aged over 65 years. The practice population is largely Asian, with 73% of the practice population being from Black and Minority Ethnicity backgrounds.

Information published by Public Health England, rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The clinical team consists of one male salaried GP, one male and two female GPs employed on a sessional basis by The Practice Group, one advanced nurse practitioner (female), two practice nurses (female) and one health care assistant (female). The team is supported by a practice manager and a team of non-clinical, administrative staff. Members of the community midwife and health visiting team operate regular clinics from the practice location. The advanced nurse practitioner (ANP) is also a registered children's nurse.

The practice operates from a three-storey purpose built property. Patient consultations and treatments take place on the ground and first levels. There is a large car park outside the surgery, with disabled parking available.

Kingsway Health Centre is open from 8am to 8pm on Mondays, Wednesdays and Thursdays, from 7.30am to 8pm on Tuesdays and Fridays and from 8.30am to 12.30pm on Saturdays. When the practice is closed out of hours services are provided by Herts Urgent Care and can be accessed via the NHS 111 service. Information about this is available in the practice and on the practice website and telephone line.



The practice provides family planning, surgical procedures, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures as their regulated activities.

Are services safe?

We rated the practice as requires improvement for providing safe services because:

- Systems for reviewing incoming pathology results had failed in the three weeks before our inspection. On the day of inspection, we found that there were 263 pathology results that had not been actioned in a timely manner. The practice were prompt to react and all outstanding results had been reviewed by the morning following our inspection.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their 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.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- Safeguarding meetings were held monthly and were well attended by both practice and community staff.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice was in the process of consolidating immunity status for all staff. We saw that all clinical staff had been asked to clarify their immunity status through provision of formal records and blood tests. Some non-clinical staff had been asked to clarify their immunity status based upon their role. Whilst formal reports were kept verifying the immunity status of clinical staff this was not the case for all non-clinical staff. We were informed on the day of inspection that the provider organisation had reviewed its policy on staff immunisations. We were sent a copy of the new policy shortly after our inspection. The practice advised that they had initiated a review of all staff vaccinations

to ensure staff were vaccinated in line with Public Health England guidance and to ensure risks to patient and staff safety were minimised. This included providing additional vaccinations and blood tests for any staff who were unable to provide supporting evidence of their immunity status.

- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- 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 including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

We reviewed the information staff needed to deliver safe care and treatment to patients and found that:

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.
- Systems for reviewing incoming pathology results had failed in the three weeks before our inspection, following a change in staffing. On the day of inspection, we found that there were 263 pathology results that had not been actioned in a timely manner. The practice was able to promptly identify that this had occurred as the

Are services safe?

member of staff who had recently taken on the assignment of pathology results to GPs had been doing so incorrectly. The practice prioritised the review of all outstanding pathology results and by the end of our inspection there were 39 results still to be reviewed. The morning after our inspection the practice advised that all results had been reviewed and that no patients had been identified as at risk due to the delay in reviewing the results. The practice provided further assurance that the risk of recurrence had been reduced through the provision of an updated pathology results handling policy with clearly defined responsibilities and actions.

Appropriate and safe use of medicines

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

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- There were effective protocols for verifying the identity of patients during telephone consultations.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to health and safety issues, including COSHH, Fire safety and Legionella. (Legionella is a term for a particular

bacterium which can contaminate water systems in buildings). Although there was not a specific health and safety risk assessment of the premises and security, we saw that the practice undertook monthly health and safety checks of the whole premises that incorporated the premises and security. If risks were identified during these monthly checks an assessment would be made to underpin any actions taken.

- The practice monitored and reviewed activity for example through review of significant events, complaints and safety alerts. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.
- We saw that The Practice Group promoted a shared approach to learning and information was disseminated centrally where possible to ensure risks to patient and staff safety were minimised.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Staff we spoke with were able to recall incidents that had occurred and learning and changes that had been developed as a consequence.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Are services effective?

We rated the practice and all of the population groups as good for providing effective services overall, except for the working age population group which we rates as requires improvement.

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' immediate and ongoing 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.
- The practice was investing in equipment to support patients' awareness and ability to manage their own health. For example, the practice was due to commence 24-hour ambulatory blood pressure monitoring for patients; a service aimed to enable more accurate blood pressure monitoring.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. Flu, pneumococcal and shingles vaccinations were offered.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines

needs were being met. For patients with the most complex needs, the GP 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins which are medicines that reduce levels of cholesterol in the blood and help reduce the risk of exacerbation of cardiovascular disease. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice's performance on quality indicators for long term conditions was largely in line with local and national averages. However, performance for diabetic patients whose condition was well controlled was below average (April 2016 to March 2017). We saw that the practice had responded proactively to improve diabetes management through the initiation of a GP led, weekly diabetic clinic. The clinic was supported by a practice nurse and we were informed that patients had responded positively to the continuity of care it offered. Clinical staff spoke positively of their satisfaction in empowering patients to manage their diabetes better in an effort to improve their overall health and well-being. Patients we spoke with were supportive of the positive impact that the clinic had provided. Unverified data provided by the practice for the period April 2017 to March 2018 appeared to demonstrate an improvement in performance for this area.

Families, children and young people:

- Childhood immunisation uptake rates were below the target percentage of 90% or above (April 2016 to March 2017). The practice was aware of the lower performance and ascertained this to the patient population who were reluctant to engage with the vaccination programme. We saw that the practice made continued efforts to encourage patients to ensure their children were

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vaccinated. This included opportunistic discussions during GP or nurse appointments, ensuring immunisation clinics were available after school and developing stronger working relationships with the health visiting team. The practice was able to provide unverified data to demonstrate that for the period April 2017 to March 2018 the practice had achieved the 90% target rate for two-year olds.

- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The advanced nurse practitioner (ANP) was also a registered children's nurse which enabled her to review children presenting with minor illnesses or injuries.
- The practice had introduced learning sessions for their young patients by holding first aid training, called Mini Medics. The training was delivered by a member of the nursing team to a group of 8 to 11 year olds and covered all aspects of first aid including basic life support and actions to take in the event of choking.

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

- The practice's uptake for cervical screening was 53%, which was below the 80% coverage target for the national screening programme. Uptake for bowel cancer screening was also lower than local and national averages. The practice informed us that patients were extremely reluctant to engage in screening programmes which they attributed to their cultural views. The practice had been proactive in encouraging patients to engage with screening programmes. For example, the practice had held health promotion events; enlisting support from bilingual staff within the provider organisation to ensure that patients would be given clear and accurate information. Patients who failed to attend screening appointments were also sent letters encouraging them to attend. The practice advised that attendance at the events had not met their aspirations but that they had seen some improvement in uptake. On the day of our inspection the practice was able to provide more recent data to support their findings; in the form of an audit undertaken of bowel screening uptake. The audit highlighted an overall improvement in the number of patients accepting invitations.
- The practice's uptake for breast cancer screening was in line with the national average.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The recruitment of the healthcare assistant had supported delivery of the NHS health checks and 206 health checks had been undertaken in the 12 months prior to our inspection. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

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 maintained a register for what it referred to as 'TLC and welfare' patients. These patients were identified as being vulnerable and requiring additional support for a variety of reasons. For example, patients with co-morbidities, housebound frail patients and patients who were frequent attenders at A&E services and/or the practice. (Co-morbidity is the presence of one or more diseases or disorders co-occurring with a primary disease or disorder). These patients were provided with a direct access number which enabled them to bypass the routine practice telephone line to book appointments or request support. A dedicated welfare champion and deputy provided ongoing support for these patients which included signposting to voluntary organisations where appropriate.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

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- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Staff received regular training around mental health issues, suicidal tendencies and dementia.
- The practice offered annual health checks to patients with a learning disability.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided which included where appropriate participation in local and national improvement initiatives. For example:

- Through joint work with the Clinical Commissioning Group (CCG), for example by auditing antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship (which aims to improve the safety and quality of patient care by changing the way antimicrobials are prescribed so it helps slow the emergence of resistance to antimicrobials thus ensuring antimicrobials remain an effective treatment for infection).
- Through participation in the Quality Outcome Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice.)
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. The Practice Group directed audit activity within the practice to ensure the best possible outcomes for patients. We saw multiple examples of audits undertaken including a three-cycle audit on failed appointment rates, with the most recent audit being undertaken in May 2018. The audit aimed to assess whether improvement methods had reduced the practice's number of failed appointments. The most recent audit highlighted a decrease of 8% in the failed appointment rate.
- Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published QOF results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 94%. The overall exception reporting rate was

7% compared with a national average of 6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) *(Please note: Any QOF data relates to 2016/17.)*

We reviewed exception reporting for the practice and were satisfied that the practice was working in line with guidelines when excepting patients. We were told that patients received two letters and phone call from the practice before being excepted. We were informed that due to the cultural habits of the practice's patient population it was often difficult to provide follow ups and reviews to patients as a large proportion of the patients requiring these appointments emigrated for prolonged periods.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- 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 and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and 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 and with other health and social care professionals to deliver effective care and treatment.

Are services effective?

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- 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.
- 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 patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.

- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- 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, for example, stop smoking campaigns, tackling obesity. Individual members of staff were given roles as health promotion champions to promote initiatives and support patients.
- We were informed that the practice had encouraged a local support service, 'Active Luton', to utilise space available at the practice. The service operated from the practice premises weekly, providing a holistic approach to supporting patients' health and social requirements.
- The practice also advised of plans to begin community outreach clinics in local mosques to provide further support for patients.

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.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Are services caring?

At our previous inspection on 20 July 2017 we rated the practice as requiring improvement for caring because:

- Data from the national GP patient survey published in 2017 showed patients rated the practice lower than others for all aspects of care.
- Feedback we received from patients we spoke with and from comment cards completed was mixed.

The practice is now rated as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients relating to the caring service provided was positive.
- The practice made continued efforts to ensure that staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice demonstrated a strong patient centric culture. For example, we were told of plans for the local fire service to attend winter flu vaccine clinics; to offer advice to elderly patients on fire safety and to ensure that they had working smoke detectors fitted in their homes.
- The practice's GP patient survey results published in July 2017 were below local and national averages for questions relating to kindness, respect and compassion. We spoke with 12 patients during our inspection and all reported that they were treated with kindness, dignity and respect by doctors and nurses. Whilst most patients were pleased with the approach of reception staff, two reported bad experiences when speaking with receptionists. We were told that all reception staff had attended training to improve their customer service skills. The practice reported a reduction in complaints received in relation to staff attitude.
- During our inspection we witnessed staff helping patients and offering support when they were experiencing difficulties. This including speaking bilingually when needed to ensure that patients' needs were met.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. The majority of practice staff were bilingual which enabled them to communicate with many patients whose first language was not English.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice encouraged patient feedback, undertaking in house surveys and encouraging patients to complete feedback forms wherever possible. Improvements made as a result of patient feedback were displayed on a 'you said, we did' noticeboard in the patient waiting area.
- The practice proactively made efforts to identify carers and supported them. The practice had appointed a carers champion and deputy to act as key contacts for carers. Staff we spoke with described difficulties they had experienced in identifying and supporting carers due to the cultural and social beliefs of large proportions of their patient population. We were told that many patients were part of large family networks who lived in shared homes, or within close proximity to one another. This meant patients were cared for by family members and often the term 'carer' was seen to be disrespectful and undermined their strong belief that supporting a family member was an inherent family matter not to be interfered with externally.
- There was a carers noticeboard in the waiting areas. The practice had a dedicated telephone number for carers to use with daily urgent appointments available. The practice had held a carers café in an attempt to offer further support but this had been repeatedly poorly attended resulting in cancellation of the initiative. In addition, the practice wrote individually to all identified carers asking them to complete a simple questionnaire to enable the practice to tailor support to their needs. Despite provision of a stamped addressed envelope the practice failed to receive any responses to the questionnaire.

Are services caring?

- The practice's GP patient survey results were below local and national averages for questions relating to involvement in decisions about care and treatment. All 12 patients we spoke with said they felt involved in decisions about their care and treatment by both doctors and nurses. Comments cards received also reflected these positive reflections. We were told that the practice had historically been unable to offer continuity of care for patients with the same clinician due to continued changes within the clinical team. We saw that the practice had worked hard to stabilise the clinical team and in turn meet the demands of their patients to see the same clinician where possible.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.
- All 12 patients we spoke with said that their privacy and dignity was always respected.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

At our previous inspection on 20 July 2017 we rated the practice as requiring improvement for providing responsive services because:

- Data from the national GP patient survey published in 2017 showed patients rated the practice lower than others for all aspects of care.
- Feedback we received from patients we spoke with and from comment cards completed was mixed.

The practice, and all of the population groups, are still rated as requires improvement for providing responsive services because:

- Feedback received from patients regarding satisfaction with access to appointments was mixed.
- Data from the national GP patient survey published in July 2017 showed patients rated the practice lower than others for access to appointments and experience of making an appointment.

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, the practice had introduced a daily phlebotomy service to improve accessibility for patients and to reduce the burden on the local hospital for the service.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- 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, 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 and for those who had difficulties getting to the practice.

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, where possible 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.
- The practice facilitated the diabetic retinal screening service, supporting not only registered patients but all diabetic patients within the locality to access services locally rather than at the local hospital.

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.
- The practice facilitated the emergency antenatal midwife clinic weekly, enabling expectant mothers with concerns to be seen locally rather than travelling to secondary care.
- The practice planned to begin provision of a specialised family planning clinic the week following our inspection.

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 appointments.

Are services responsive to people's needs?

- The practice actively promoted the use of online services to improve access for patients unable to telephone or attend the practice during normal working hours.
- The practice had signed up to the Electronic Prescribing Service (EPS), enabling patients to collect their prescriptions from a pharmacy of choice.
- The practice also used Mjog technology to enable two-way digital communications with patients.
- The practice website was routinely maintained, offered an alternative channel of communication for patients and encouraged patients to provide feedback.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

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.
- The practice had a dedicated dementia champion and these patients were provided with a bypass number upon diagnosis to enabling them to access support urgently when needed.
- The practice facilitated a mental health professional who ran a weekly clinic to support patients. Appointments could be booked directly by patients or by the practice team as required.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Some of the patients we spoke with reported difficulties with the appointment system.

- The practice's GP patient survey results published in July 2017 were below local and national averages for questions relating to access to care and treatment.

The practice was aware of continued dissatisfaction from patients regarding access and of the continued low performance in the national GP survey. An action plan had been developed, was reviewed regularly and actions were completed where possible. The practice provided extensive opening hours (including bank holidays) within its extended hours provision. We saw that appointment numbers were in line with the contractual requirements and that the practice was innovative in trying to increase access to clinicians. For example, through the use of an advanced nurse practitioner (ANP) who was able to review patients with specific symptoms or conditions. We were told that patients had been initially reluctant to see the ANP but patient feedback for the ANP from those who had agreed to see her was positive.

The practice had upgraded their telephone system in January 2018. The new system enabled more calls to be answered and the practice had increased staffing during busy periods to improve wait times. Staff we spoke with described how patients had been reluctant to trust improvements had been made to the telephone system and as a result patients, repeatedly queued outside the practice from 7.30am to book appointments. The practice provided data that showed an average call rate of 3,400 calls per week (more than a third of their patient list), with the highest number of calls being received on Mondays. The practice had actively promoted the use of online services to try and reduce the burden on the telephones and to enable patients to access services efficiently.

Staff described their own experiences of the high demands placed on the service from patients repeatedly requesting multiple appointments; often for conditions or symptoms where a GP appointment was not needed. The practice had made efforts to signpost and educate patients on appropriate use of GP services and alternative sources of support but had seen little engagement from patients.

We spoke with 12 patients on the day of inspection and of those the majority advised that although the telephone lines were busy they were able to get an appointment when needed. Some patients advised that they would go to the practice rather than telephone to ensure that they received an appointment. One person informed that the telephone line was busy from 7am despite the practice not

Are services responsive to people's needs?

opening until 8am. All the patients we spoke with advised that they were able to get an appointment when needed. We spoke with patients about the number of appointments they had received over the last month. The majority had received multiple appointments, with one patient informing us they had received 20 appointments over the previous two months.

The practice informed us that data they had analysed showed that 10% of their patient population were utilising 44% of the available appointments. We were told of initiatives used to try and educate patients away from overuse of the service. For example, patients utilising multiple appointments every month were offered one double length appointment each month to enable them to focus their needs and enable appropriate support when needed. Further data analysis had identified that patients most frequently using the service suffered from diabetes or had mental health concerns. In an effort to improve this, in addition to the diabetic clinic, the practice facilitated a mental health professional to run a dedicated clinic each week.

Despite multiple efforts, the practice had seen little improvement in patient satisfaction in relation to access. The practice had repeatedly educated patients on appropriate use of services and signposted to pharmacies where appropriate, however patients continued to request GP appointments for all their health concerns. We were told of plans to attempt to improve access through education of younger generations within the local community. It was envisaged that as these children often attended with

parents or grandparents, occasionally acting as interpreters, early education on appropriate GP service use may improve access in the future. It was envisaged that clinical staff would visit schools to provide talks and interactive sessions for children. These sessions would be entitled 'Don't be afraid of the Doctor', with plans to ensure children who may be vulnerable or at risk also felt confident to use the GP service for support if needed. Information on self-care and use of pharmacies would be incorporated in these talks.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, following receipt of a complaint regarding the delay in actioning a discharge summary for a patient, GPs were provided with dedicated time to ensure that all discharge summaries could be reviewed and actioned in a timely manner.

Please refer to the evidence tables for further information.

Are services well-led?

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 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 provider organisation, The Practice Group, had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- The Practice Group were aware of some challenges they faced in managing salaried and self-employed GPs who often took a reactive rather than proactive approach to service delivery. For example, the missed pathology results discovered on the day of inspection had not been identified by GPs as they were only assessing results assigned to them and were ignoring the overall outstanding number of results. The updated policy we were sent aimed to address this by assigning clinical and non-clinical responsibility to management of results. The Practice Group discussed methods they were implementing within their organisation to encourage more ownership of responsibility within practices, for example asking practices to undertake their own searches and audits rather than facilitating them centrally.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

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. We were told of regular training and learning events held at the practice to upskill both clinical and non-clinical staff.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. 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.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control

Are services well-led?

- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective 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. However, some processes needed reviewing. In particular, systems for processing pathology results to ensure timely clinical review had been ineffective in the three weeks prior to our inspection due to a change in staffing.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. The Practice Group maintained a routine audit cycle, incorporating additional audits where needed in response to identified risks or changes in national guidance. 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 considered and understood the impact on the quality of care of service changes or developments.

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 Practice Group provided monthly reports on practice performance which incorporated comparative data to other practices within the group. Data generated related to appointment

provision and usage along with QOF and Public Health England performance indicators. Information was used to plan services and allocate resources and support where needed.

- 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.
- There was a patient participation group and efforts were made to encourage activity. We spoke with the vice-chairman of the PPG who advised that the practice was forthcoming with information and was actively trying to encourage more members to join the PPG. In response to patient feedback the practice was planning to develop a virtual PPG.
- 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. In particular, the practice's efforts to improve patient satisfaction, encourage appropriate self-care and improve uptake of national screening programmes were unyielding.
- 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.

Are services well-led?

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>Where responsibility for the care and treatment of service users was shared with, or transferred, to other persons, the registered person did not ensure that timely care planning took place to ensure the health, safety and welfare of those service users. In particular:</p> <ul style="list-style-type: none">• Systems for reviewing incoming pathology results had failed in the three weeks before our inspection. On the day of inspection, we found that there were 263 pathology results that had not been actioned in a timely manner. The practice were prompt to react and all outstanding results had been reviewed by the morning following our inspection.