Highfield Surgery Partnership

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Highfield Surgery Partnership on 15 July 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- The practice received patient safety alerts and acted appropriately. However, they did not keep records of patient safety alerts for any possible temporary members of staff such as locum doctors.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe. Medicines in GP bags were appropriate and in date although there was no formal process to check these on a regular basis.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had introduced an acute care service to manage up to 200 patient requests for urgent care each day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There were protocols relevant to infection control in place and staff had received up to date training. We noted that there was no overall infection control policy that referenced these protocols or provided details of the infection control lead.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had experienced difficulties in involving all staff in meetings and had addressed this by introducing a weekly communication flier which was circulated to all staff.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

- The practice had arranged training for one member of administrative staff in the testing of electrical equipment and purchased electrical testing equipment. This staff member was then able to check all practice electrical equipment on a rolling programme.

The areas where the provider should make improvement are:

- Ensure that patient safety alerts are retained by the practice for reference by temporary staff such as locum GPs.
- Put a formal process in place to check the medicines carried in GP bags to ensure that they are all in date.
- Introduce overarching infection prevention and control policy for the practice.

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

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- The practice received patient safety alerts and acted appropriately. However, they did not keep records of patient safety alerts for any possible temporary members of staff such as locum doctors.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe. Medicines in GP bags were appropriate and in date although there was no formal process to check these on a regular basis.
- There were protocols relevant to infection control in place and staff had received up to date training. We noted that there was no overall infection control policy that referenced these protocols or provided details of the practice infection control lead.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice maintained appropriate standards of cleanliness and hygiene. However, we saw fabric-covered notice boards in treatment rooms that had not been risk-assessed or listed separately in the practice cleaning schedule.
- Risks to patients were assessed and well managed. The practice had arranged training for one member of staff in the testing of electrical equipment and purchased electrical testing equipment. This staff member was then able to check all practice electrical equipment on a rolling programme.

Are services effective?

Good

The practice is rated as good for providing effective services.

Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement. For example, the practice had improved patient access to its service for the management of patients with urgent needs.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. The practice held monthly meetings to discuss patient unplanned admissions to hospital as well as monthly meetings to discuss patients with complex needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients said staff at the practice went the extra mile when needed.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had appointed a "carers' champion" whose role was to offer a point of contact for carers on the practice list, liaise with the local carers support organisation, offer health checks and information packs on support services and optimise the identification of carers on the practice patient list.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to

Summary of findings

services where these were identified. They worked with the CCG and neighbouring practices to develop community services in the area and provide training in the management of patient chronic disease.

- Patients said they found it easy to make an appointment with a named GP although they sometimes had to wait a while and there was continuity of care, with urgent appointments available the same day. The practice acute care service managed up to 200 patient requests for urgent care each day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice held monthly team meetings for GPs and team leaders in the practice who then fed back to their respective teams. The practice had experienced difficulties in involving all staff in meetings and had addressed this by introducing a weekly communication flier which was circulated to all staff.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. The practice was expanding its PPG to include a virtual group of patients who could communicate by email or letter.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels. The practice had piloted an electronic information-sharing project for the clinical commissioning group (CCG).

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

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had a memory assessment clinic for patients every month.
- A national charity provided two clinics every week in the practice to offer patients social care advice.
- The practice had invited members of the national patient bowel screening service to promote screening to patients in the surgery waiting area.
- The practice had a prescription clerk available each morning to answer queries for patients who were experiencing difficulties in ordering repeat prescriptions.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Blood pressure measurements for diabetic patients showed that 86% of patients had readings within the recommended levels compared with the national average of 78%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice worked with neighbouring practices to deliver training to the community nursing team in the management of patient chronic disease.

Families, children and young people

Good

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

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for the vaccinations given were comparable to clinical commissioning group (CCG) averages except those given to children under one year of age which were lower.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 78%, which was comparable to the CCG average of 81% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- There were appointments with a GP on Monday and Tuesday until 7pm and late opening on those days until 7.30pm.
- 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.
- The practice acute care service offered telephone appointments to working patients who needed urgent advice during working hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

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

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice nurse manager acted as the practice care co-ordinator and produced and reviewed care plans for vulnerable patients, contacting all patients when they were discharged from hospital.
- The practice recognised that it had many older, housebound patients and that 3% of their patients were living in care homes. They employed a specialist community nurse to provide care for these patients in their own homes. One of the practice nurse practitioners also visited housebound patients.
- The practice had access to an online service that enabled staff to print off patient information leaflets in easy read format. This same service provided video information on health using British sign language and videos for patients on subjects such as healthy living and chronic disease which were easy to understand.
- The practice had recently appointed a carers' champion who was supported by two deputies. The carers' champion's role was to offer a point of contact for carers on the practice list, liaise with the local carers support organisation, offer health checks to carers and information packs on support services and optimise the identification of carers on the practice patient list.
- The practice had a policy for managing the care of patients who were lesbian, gay, bisexual or transgender (LGBT).
- One of the practice nurse practitioners was the main point of contact for patients with learning difficulties and invited those patients for annual health checks, visiting them at home if they were unable to come to the practice.

People experiencing poor mental health (including people with dementia)

Good

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

- 96% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the national average of 88%.

Summary of findings

- 90% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice was able to refer patients to adult mental health services which were based in the practice building, to provide patient assessment and treatment.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages. 275 survey forms were distributed and 113 were returned (41%). This represented 0.8% of the practice's patient list.

- 78% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 77% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 94% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 92% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards which were all positive about the standard of care received. Patients praised the high level of service at the practice and the professionalism and friendliness of the staff. Patients also commented that they felt listened to by staff and that they felt valued.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Data from the practice friends and family test showed that during the last month of data collection, there were 18 responses all of which said that they were extremely likely or likely to recommend the practice to friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that patient safety alerts are retained by the practice for reference by temporary staff such as locum GPs.
- Put a formal process in place to check the medicines carried in GP bags to ensure that they are all in date.
- Introduce overarching infection prevention and control policy for the practice.

Outstanding practice

- The practice had arranged training for one member of administrative staff in the testing of electrical equipment and purchased electrical testing equipment. This staff member was then able to check all practice electrical equipment on a rolling programme.

Highfield Surgery Partnership

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, a practice nurse specialist adviser, and an Expert by Experience (an Expert by Experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service and who has received training in the CQC inspection methodology).

Background to Highfield Surgery Partnership

Highfield Surgery Partnership is housed on the second (top) floor of the modern, purpose built South Shore Primary Care Centre in the South Shore area of Blackpool.

There is onsite parking available and the practice is close to public transport. The practice provides services to 13,744 patients.

The practice provides level access for patients to the building with automated entry doors and is adapted to assist people with mobility problems. The building has three floors, and the practice reception, consulting and treatment rooms are mainly on the second (top) floor. The practice also operates a service for managing patients with acute problems which is situated on the first floor, although this is not a walk-in service for patients. Access to the practice is by using stairs or one of two lifts.

The practice is part of the NHS Blackpool Clinical Commissioning Group (CCG) and services are provided under a General Medical Services Contract (GMS).

There are three male and three female GP partners and two male and two female salaried GPs. The practice is a training practice and two GPs are accredited trainers. The practice also employs three nurse practitioners, a nurse manager, three pharmacists, three practice nurses, a treatment room nurse and five health care assistants. The non-clinical team consists of a practice manager and 25 administrative and reception staff including two assistant practice managers and a reception manager who support the practice.

The practice is open between 8am and 7.30pm on Monday and Tuesday and 8am and 6.30pm on Wednesday to Friday. When the practice is closed, patients are able to access out of hours services offered locally by the provider Fylde Coast Medical Services by telephoning 111.

The practice has a larger proportion of patients aged over 45 years of age compared to the national average and 22.3% of the practice population are aged over 65 years of age compared to the national average of 17%.

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

The practice caters for a larger proportion of patients experiencing a long-standing health condition (60% compared to the national average of 54%). The proportion of patients who are in paid work or full time education is higher (60%) than the CCG average of 52% and unemployment figures are lower, 3% compared to the CCG average of 7% and the national average of 5%.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as

Detailed findings

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 July 2016. During our visit we:

- Spoke with a range of staff including the practice manager, four GPs, a practice pharmacist, the nurse manager, a nurse practitioner, a practice nurse, a health care assistant and three members of the practice administrative team and spoke with six patients who used the service including three members of the practice patient participation group (PPG).
- Observed how staff interacted with patients and talked with family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. There were formal quarterly practice meetings where these were discussed and ad hoc meetings at the time of the event. Details of significant events were held on the practice intranet system for all staff.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice improved the procedures for dealing with patient collapse in the surgery by ensuring that all staff were aware of the location and provision of emergency equipment to deal with patient collapse. This was later audited by the practice manager to ensure compliance.

The practice did not keep records of patient safety alerts for any possible temporary members of staff such as locum doctors.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. All of the safeguarding policies and contact information was kept in one place on the practice intranet. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level 3. The practice held informal "coffee" meetings every day that were open to practice and community staff. This gave the opportunity for discussion with the health visitor at least once a week for any patient concerns.
- 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). Only clinical staff in the practice acted as chaperones.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. However, we saw fabric-covered notice boards in treatment rooms that had not been risk-assessed or listed separately in the practice cleaning schedule. The nurse manager was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There were protocols relevant to infection control in place and staff had received up to date training. We noted that there was no overall infection control policy that referenced these protocols or provided details of the practice infection control lead. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Medicines in GP bags were appropriate and in date

although there was no formal process to check these on a regular basis. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice pharmacists carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. The three nurse practitioners and two pharmacists had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines against a patient specific direction from a prescriber.

- We reviewed seven personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). The majority of administrative staff had not received DBS checks but the practice had carried out risk assessments relevant to their role.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the administration office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. The practice had arranged training for one member of administrative staff in the testing of electrical equipment and purchased electrical testing equipment. This staff member was then able to check all practice electrical equipment on a rolling programme. We saw that all electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice had arrangements for staff to cover each other in the event of holidays or absence including taking over lead responsibilities. The practice had recruited an additional salaried GP to start in August 2016.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place 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 and there were emergency medicines available in the practice.
- There were two emergency trollies available, one upstairs in the practice clinical storeroom and one downstairs in the clean utility room in the practice area for the management of patients with acute problems. Both trollies were supplied with all emergency equipment and medicines.
- The practice had two defibrillators available on the premises and oxygen with adult and children's masks. First aid kits and accident book were available.
- Emergency medicines were easily accessible to staff in secure areas of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments and audits.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available. Exception reporting figures for the practice were comparable to the clinical commissioning group (CCG) and national averages (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 2014-2015 showed:

- Performance for diabetes related indicators was similar to or better than the national average. For example, the percentage of patients who had their blood sugar levels well-controlled was 77% compared to the national average of 78% and the percentage of patients with blood pressure readings within recommended levels was 86% compared to the national average of 78%.
- Performance for mental health related indicators was better than the national average. For example, 96% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the national average of 88% and 90% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the national average of 84%.

There was evidence of quality improvement including clinical audit.

- There had been numerous clinical audits completed in the last two years. Many of these were medication audits and the majority of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, recent action taken as a result improved patient access to the practice service for the management of patients with acute needs. New protocols were introduced and staff trained in their use so that patient requests for certain acute medicines were better managed by reception staff and demands on the acute problem management service reduced. After the introduction of the new protocols measured over a period of seven weeks, the number of medication requests passed to the acute care service decreased from 21% to 5%.

Information about patients' outcomes was used to make improvements such as reviewing and revising protocols for use in practice when changing certain medications for patients.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nursing staff were trained in patient end of life care and the mental capacity act.
- The practice worked with neighbouring practices to deliver training to the community nursing team in the management of patient chronic disease.

Good

Are services effective?

(for example, treatment is effective)

- 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. All clinical staff who administered vaccines had an annual update.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months where the training that they had completed that year was monitored and discussed.
- Staff received training that included: safeguarding, fire safety awareness, basic life support, dementia awareness and information governance. Staff had access to and made use of e-learning training modules, in-house training and training from external providers.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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. The nurse manager acted as the practice care co-ordinator and produced and reviewed care plans for vulnerable patients, contacting all patients when they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients who had been unexpectedly admitted to hospital in the last month. Separate meetings with other health care professionals also took place monthly for patients receiving end of life care and those with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- When a patient requested that a chaperone was present at an intimate examination both the examining clinician and the chaperone recorded this in the patient record.
- Staff had trained online on seeking patient consent and had attended further in house training to develop understanding of the various forms of consent.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and patients with mental health problems. Patients were signposted to the relevant service.
- A patient memory assessment clinic was available on the premises every month and smoking cessation advice was available from a local support group. A national charity provided two clinics in the practice every week to offer social care advice.
- The practice was able to refer patients to adult mental health services which were based in the practice building, to provide patient assessment and treatment.

The practice's uptake for the cervical screening programme was 78%, which was comparable to the CCG average of 81% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated

Good

Are services effective?

(for example, treatment is effective)

how they encouraged uptake of the screening programme by promoting the service in patient waiting areas and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice had recently invited representatives from the screening services to promote screening with patients in the practice waiting area. Figures for patient attendance at the national screening services were above local CCG averages. For example, attendance at breast screening was 72% (CCG average 66%) and attendance at bowel screening 58% compared to the CCG average of 49%.

The practice had also arranged for other services such as the fire service to offer advice to patients in the patient waiting area.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages except those given to children under one year of age which were lower. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 87% to 96% (CCG rates 90% to 97%) and five year olds from 83% to 99% (CCG rates 87% to 97%). Rates for children under one year of age were 81% to 90% compared to the CCG averages of 94% to 96%.

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.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the 22 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. Patients also commented that staff at the practice went the extra mile when needed.

The practice had a policy on treating patients with dignity and respect.

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

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

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) and the national average of 89%.
- 86% of patients said the GP gave them enough time compared to the CCG and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and the national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Staff at the practice supported local organisations and charities including the local hospice, cancer charities and the lifeboat institution in raising funds for their services.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. If a referral to another service was needed, the GP aimed to book an appointment for the patient at the time of the consultation. We also saw that care plans were personalised.

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

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and the national average of 86%.
- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.
- 97% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- The practice had access to an online service that enabled staff to print off patient information leaflets in

easy read format. This same service provided video information on health using British sign language and videos for patients on subjects such as healthy living and chronic disease which were easy to understand. Access to this service was made available to all staff on the practice intranet so that clinicians could use it during patient consultations.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 299 patients as carers (2.2% of the practice list). Written information was available to direct carers to the various avenues of support available to them. The practice had recently appointed a carers' champion who was supported by two deputies. The carers' champion's role was to offer a point of contact for carers on the practice list, liaise with the local carers support organisation, offer health checks to carers and information packs on support services and optimise the identification of carers on the practice patient list.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice worked with the CCG and other practices in the area to help to develop increased community services for housebound patients.

- The practice offered a 'Commuter's Clinic' on a Monday and Tuesday evening until 7.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability or with complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice recognised that it had many older, housebound patients and that 3% of their patients were living in care homes. They employed a specialist community nurse to provide care for these patients in their own homes. One of the practice nurse practitioners also visited housebound patients.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Although the practice did not take requests for repeat prescriptions routinely over the telephone, they had a prescription clerk available each morning to answer queries for patients who were experiencing difficulties in ordering repeat prescriptions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice patient participation group (PPG) helped to write most of the practice information leaflets to ensure that they were free of jargon. Some of these leaflets were given to new patients in a registration pack.
- There were disabled facilities, a hearing loop and translation services available.
- All staff had access to an online service to provide information to patients in an easy read format or video. Videos were available in British sign language.
- The practice had a policy for managing the care of patients who were lesbian, gay, bisexual or transgender (LGBT) which had been reviewed and revised following a patient complaint.
- One of the practice nurse practitioners was the main point of contact for patients with learning difficulties and invited those patients for annual health checks, visiting them at home if they were unable to come to the practice.

Access to the service

The practice was open between 8am and 7.30pm Monday and Tuesday and 8am to 6.30pm Wednesday to Friday. Appointments with GPs were from 8am daily with the last bookable appointment at 7pm on Monday and Tuesday, 5.25pm on Wednesday, 5.40pm on Thursday and 3.40pm on Friday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

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

- 93% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 78% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

The practice had looked at the GP patient survey results and had acknowledged that staff turnover had affected the telephone answering service. The practice had recruited additional staff and hoped that this would help to increase patient satisfaction in this area.

The practice operated an acute care service every day until 5pm to manage patient requests for same day appointments. This service was run by two practice GPs and two nurse practitioners and could take as many as 200 requests daily. Members of the reception team listed patients on the practice computer who requested urgent appointments and the acute care team telephoned them back to arrange a face-to-face appointment, deal with the problem on the telephone or arrange for a home visit if necessary. The team aimed to call all patients back within two hours and the list for these patients was not limited.

Good

Are services responsive to people's needs?

(for example, to feedback?)

People told us on the day of the inspection that they were able to get appointments when they needed them. There was some criticism regarding waiting to see a particular GP but all said that the acute care service was good.

All patient requests for home visits were listed on the acute care service list and patients were contacted by the acute care team. The GP visited these patients as required with the daily on-call GP visiting patients who had more urgent 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 an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a poster and a patient complaints leaflet available in the waiting area. Patients told us that they knew how to complain if they needed to.

We looked at 13 complaints received in the last 12 months and found they had all been dealt with in a timely way with openness and honesty. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, following a complaint from a patient regarding a referral that had not been made by a GP registrar working in the practice, all staff were reminded of the need to ensure that referrals were made on the day of the patient consultation.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a practice charter which was published on the practice website and staff knew and understood the values.
- The practice had strong strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice had produced a summary of goals and objectives for development from the business plans.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff on the practice intranet.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. One of the GP partners was a member of the clinical commissioning group (CCG) board which ensured direct communication with the CCG. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour and had a duty of candour policy. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held monthly team meetings. These meetings were attended by all GPs and team leaders in the practice who then fed back to their respective teams. The practice had experienced difficulties in involving all staff in meetings and had addressed this by introducing a weekly communication flier which was emailed to staff and posted in hard copy on practice notice boards.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues with the managers and felt confident and supported in doing so. We noted that there was a practice-funded social event for staff annually.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. Staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice had undergone a major area of change when it merged with a neighbouring practice in 2013 however, there was a very low staff turnover with staff leaving mainly due to retirement. Some staff members had been in the practice for more than 15 years.

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

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

Are services well-led?

Good

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had conducted a surgery premises accessibility survey for the practice which had raised issues regarding parking for practice patients. The practice had started discussions about this with the building owners and written to the CCG. The latest survey organised by the practice and the PPG was to assess whether patients were going to pharmacies rather than the practice to receive influenza vaccinations. The practice had yet to formally analyse the survey results, however early indications were that the practice needed to give patients better access to clinics. The practice was therefore planning to introduce open clinics this year to encourage patient attendance.
- The practice planned to extend the PPG by creating a virtual group of patients who could be communicated with by email or letter rather than face-to-face.
- The practice had gathered feedback from staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had piloted the CCG project which aimed to share electronic patient information securely between practices, the out of hours service, the local hospice and the hospital. The practice manager attended the information technology development group quarterly.

Two of the practice GPs provided support to the new community service that managed patients over 60 years of age who had complex chronic conditions.

The practice was a training practice and provided support and mentorship to medical students and GP trainees at different stages of their learning.