

Queens Road Surgery

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

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	7
What people who use the service say	11

Detailed findings from this inspection

Our inspection team	12
Background to Queens Road Surgery	12
Why we carried out this inspection	12
How we carried out this inspection	12
Detailed findings	14

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Queen Road Surgery on 1 August 2017. 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 a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We saw one area of outstanding practice:

A bespoke digital software tool was used by staff at the practice to improve safety and clinical outcomes and, in addition, enabled the practice to monitor recruitment and training. The system recorded all staff training and

Summary of findings

monitored the expiry dates clinical staff's professional registrations. Searches were regularly run at the practice which highlighted staff who required training or which professional registrations needed to be checked. The system also enabled the practice pharmacist to ensure compliance with medicines safety alerts and that patient medicines were optimised in accordance with current best practice. In addition the practice used the software to analyse patient data to ensure those with long term conditions were identified, coded and called in for periodic reviews. As a result of the software's analysis which looked at risk factors and patient medicines, the practice increased the number of patients on their asthma register by 29% and those on their pre diabetic register by 118% between April 2016 and August 2017. The software had also been used to generate information used for an audit of diabetic patients which show a significant increase in patients who had blood sugar levels within the optimal range.

The areas where the provider should make improvement are:

- Discuss the system used to triage patients with staff to ensure that all staff are aware of their roles and responsibilities.
- Take steps to ensure that Patient Group Directions include the practice name when these are renewed.
- Consider storing all practice policies in a single location to ensure that staff are able to access these easily.
- Continue to review staffing levels in the administrative team to ensure that there are sufficient numbers of staff.
- Take steps to monitor and mitigate risks to staff and patients including the risk of legionella.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- From the documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety. However we were told by one staff member that they would refer patients to a pharmacist for minor ailments without the patient first being triaged by a clinician.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had good arrangements in place in respect of the management of medicines. However we found that none of the nurses Patient Group Directions (PGDs) had been completed with the practice's name.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge 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.
- End of life care was coordinated with other services involved.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for some aspects of care and were comparable for most others.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example the practice participated in a locality wide initiative delivering holistic health assessments to patients over 65 who were housebound or who had not attended the practice in 18 months and for all patients over the age of 80 years old. The aim of the assessment was to develop a care plan which addressed both the health and social needs of these patients through provision of support by the practice, other healthcare organisation and agencies in the voluntary sector.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from the examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

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 both within the practice and in the wider corporate organisation that oversaw activities

Good



Summary of findings

at this location. Staff felt supported by management. The practice had policies and procedures to govern activity and held regular meetings where governance issues were discussed. Governance meetings were also held at the corporate level. Information regarding significant events and best practice were fed back to senior management and learning or improvement work was cascaded back to individual practice level.

- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training was encouraged for staff at all levels by AT Medics who provided job specific in house training at all levels of the organisation.
- The provider was aware of the requirements of the duty of candour. We saw evidence the practice had system in place to ensure compliance with these requirements.
- Leadership both local within the practice and in the wider corporate organisation encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority.

Summary of findings

The six population groups and what we found

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

Older people

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. The practice participated in a locality initiative whereby comprehensive reviews were undertaken and care plans drafted for patients over the age of 65 who were housebound or who had not attended the practice in a significant period of time or who were aged over 80. This aimed to address both patient's health and social needs. One hour appointments were offered for these assessments.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared with other with local care services. For example the practice would liaise with a local geriatrician over the telephone and discuss patients at community multidisciplinary team meetings.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

Good



People with long term conditions

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

- Staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments were offered for patients with long term conditions which clinicians used to undertake reviews and draft care plans.

Good



Summary of findings

- The practice performed in line with local and national averages in respect of the management of diabetes.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- The practice used bespoke IT software created by AT medics to improve identification of patients with long term conditions. For example between April 2016 and August 2017 the number of patient identified as pre diabetic increased by 118%.
- All these patients had a named GP and there was a system to recall patients for 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.

Families, children and young people

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

- From the sample of documented examples we reviewed 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.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Staff told us on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice would provide support for premature babies and their families following discharge from hospital.
- Preconception advice was offered to patients with long term conditions including those with epilepsy and diabetes.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice hosted community midwives and worked health visitors to support this population group.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- A bespoke ante and post-natal care planning template created by AT Medics to ensure that pregnant women and those who had just given birth had their needs fully assessed and supported. The ante natal template calculated risk in

Good



Summary of findings

pregnancy, assessed FGM and safeguarding risk within the family and assessed the mental health of expectant mothers. The template also prompted GP to check for gestational diabetes and MMR status. Post-natal care template again assessed mental health and ensured that complications resulting from pregnancy were assessed and acted upon. The practice planned to share the templates with other practices in the wider locality once they had thoroughly tested them.

Working age people (including those recently retired and students)

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours.
- 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.
- Patients could also be referred to the local primary care extended access service which provided appointments from 8 am to 8 pm seven days per week.

Good



People whose circumstances may make them vulnerable

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. We were told that homeless patients could register at the practice.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability. Carers for these patients were invited to attend and offered an assessment.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may

Good



Summary of findings

make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

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

- The practice carried out advance care planning for patients living with dementia.
- 88% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. Patients were invited by text, call and letters for reviews and sent reminders to increase the likelihood of attendance.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs. Reviews were undertaken on a monthly basis.
- Performance for other mental health indicators was comparable to local and national averages.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia. Longer appointments were offered to those deemed to have limited capacity.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages. Three hundred and sixty seven survey forms were distributed and 100 were returned. This represented 1.6% of the practice's patient list.

- 93% of patients described the overall experience of this GP practice as good compared with the CCG average of 79% and the national average of 85%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.

- 86% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 73% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 17 comment cards which were all positive about the standard of care received.

We spoke with 10 patients during the inspection. Nine patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. One patient told us that they were unhappy with the care they received from the practice.

Queens Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC Lead Inspector. The team included a GP specialist adviser and an Expert by Experience.

Background to Queens Road Surgery

Queens Road Surgery is based in Southwark CCG and serves approximately 6100. The practice is registered with the CQC for the following regulated activities Diagnostic and screening procedures Treatment of disease, disorder or injury Maternity and Midwifery Services

The practice is located in an area ranked two out of 10 index of multiple deprivation (a scale used to measure deprivation a score of one being the lowest). The practice population is ethnically diverse with 7% of patient having mixed ethnicity, 8% Asian, 43% black and 4% described as within other non-white ethnic groups. The practice population has higher levels of deprivation affecting children and older people and a significantly larger proportion of working age people compared with the national average.

The practice is run by AT Medics Limited. There is one GP director who undertakes one session per week at the practice, three salaried GPs and two regular long term locums who undertake 20.5 sessions between them. There is a practice based pharmacist who works 0.6 of a whole time equivalent and there is a full time practice nurse.

The practice is open Monday to Friday. Opening hours are between 8 am till 8 pm Mondays and Thursdays. The

practice closes at 6.30 pm the rest of the week.

Appointments are available during these times. Extended hours appointments are offered between 6.30 pm and 8 pm Monday and Thursday.

Queens Road Surgery operates from 136 Meeting House Lane, London, SE15 2UA which premises are rented from another GP surgery that previously occupied the address. The service is accessible to patients with mobility problems as all consulting rooms are located on the ground floor.

Practice patients are directed to contact the local out of hour's provider when the surgery is closed.

The practice operates under a Alternative Provider Medical Services (APMS) contract, and is signed up to a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These are: Meningitis provision, Childhood Vaccination and Immunisation Scheme, Extended Hours Access

Facilitating Timely Diagnosis and Support for People with Dementia, Influenza and Pneumococcal Immunisations, Patient Participation and Rotavirus and Shingles Immunisation and Unplanned Admissions.

The practice is part of GP Federation Independent Health Limited.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

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. We carried out an announced visit on 1 August 2017. During our visit we:

- Spoke with a range of staff (The Clinical Director, GPs, the practice nurse and healthcare assistant, the practice manager and reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with family members
- Reviewed a 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.
- Looked at information the practice used to deliver care and treatment plans.

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 living with dementia).

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

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice submitted an urgent secondary care referral which was not followed up after a period of two weeks. The practice reviewed their system for two week urgent referrals. A daily search was undertaken by administrative staff to ensure that all urgent referrals had been tasked, sent and logged on their monitoring spreadsheet.
- The practice also monitored trends in significant events and evaluated any action taken. Significant events that were deemed to be particularly serious were discussed a regional and senior management levels and learning was disseminated across AT Medics.

Overview of safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs, nurses, the practice pharmacist and the practice's healthcare assistant were trained to child protection or child safeguarding level three. The non-clinical staff were trained to safeguarding level one.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice had created new alerts for vulnerable children and adults on the clinical system to ensure that they were more visible to those reviewing patient records. All newly registered children would be booked an appointment with a nurse within 30 days in order for the practice to identify any possible safeguarding issues and ensure that the patient's immunisations were up to date.

The practice maintained appropriate standards of cleanliness and hygiene.

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

Are services safe?

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

There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group 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 to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). None of the PGDs included the practice's name. All PGDs were amended to include this information on the day of the inspection.

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

The practice operated a telephone triage system whereby all patients who requested an emergency on the day appointment were called back by a clinician who would assess the need for an appointment. One receptionist we spoke with on the day told us that they would refer people to the pharmacy for some minor ailments without clinical advice and we confirmed there were no protocols or guidance in place to enable them to do this. All other reception staff we spoke with were aware of the triage system and clinical and management staff confirmed that all patients who requested an appointment would be called by a clinician.

Monitoring risks to patients

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

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice had identified that the water coming from some taps in the premises was at temperatures that could promote the growth of legionella. The practice had contacted the manufacturer of the taps who stated that the default setting for the taps prevented the temperature from going above 41 degrees. The practice had put signs up instructing staff not to use the taps and had alerted their maintenance team could recalibrate the taps to produce higher temperatures.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. Administrative staff told us that two reception and administrative staff had recently left the practice which had created additional work for staff at reception resulting in some non-urgent tasks being delayed. However we were also informed that the practice were currently recruiting for new staff and that, in the interim, the team were helping each other to ensure that there were no delays in respect of urgent work and minimising delays in progressing lower priority tasks.

Arrangements to deal with emergencies and major incidents

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

Are services safe?

- 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 treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to 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 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%.

The practice exception reporting rate was 9.7% compared with the local average of 6.7% and the national average of 9.6% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

- The practice informed us that they had the second highest prevalence of diabetes in the CCG. Performance for diabetes related indicators was similar to the CCG and national averages. For example the percentage of patients with well controlled blood sugar levels was 71% compared with the local average of 71% and the national average of 77%. The practice's rate of exception reporting for this indicator was 10% compared to the CCG average of 7% and the national average 13%. The

percentage of patients with well control cholesterol was 86% compared to a local average of 82% and a national average of 80%. The rate of exception reporting was 8% compared to 8% in the CCG and 13% nationally.

- Performance for mental health related indicators was similar to the CCG and national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months was 91% compared to the local average of 87% and the national average of 89%. The rate of exception reporting was 3% compared to a local average of 5% and a national average of 12%. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 88% compared to the local average of 85% and the national average of 83%. The exception reporting was 11% compared to the local average of 5% and the national average of 6%. We raised this with the practice on the day of the inspection and the practice told us that there were two patients exception reported in 2015/16 and these patients had automatically been exception reported having being diagnosed within three months of registering with the practice. Only one patient had been exception reported in 2016/17 (5% exception reporting) and again this patient had been automatically exception reported for the same reason.

There was evidence of quality improvement including clinical audit:

- There had been five clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, we reviewed one audit related to the reviewing patients with diabetes with a view to increasing the number of patients with well controlled blood sugar levels. The practice ran the initial audit and found that 235 patients had well controlled blood sugar levels. GPs at the practice then initiated a management plan for each of the patients who were deemed not to have well controlled blood sugar. They also introduced patients to new medications, referred them to specialist

Are services effective?

(for example, treatment is effective)

diabetes services or increased the doses of current medication. The number of patients with well controlled diabetes increased to 301 when the second cycle review was done 12 months later.

- The practice also participated in virtual clinics for long term conditions including diabetes, whereby practice staff would review complex patients with the support of a specialist consultant. Care plans and treatment would then be optimised in accordance with current best practice.
- The practice continually undertook reviews using bespoke software created by AT Medics which enabled searches to be run and action taken by the practice pharmacist to ensure that medicines safety alerts were actioned, medicines were optimised in line with current guidelines and that patients with long term conditions were identified; using information regarding the medicines they were prescribed. The practice provided an example of 11 reviews undertaken related to medicines safety and optimisation. All of which showed improvement between the first and second review of between 46% compliance and 100%. The software generated qualitative information regarding each patient considered under the review including the steps that the practice had taken to improve the patient's care and treatment at the first review and whether or not this had been effective at the second review.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the clinical lead had obtained a diploma in diabetic care to enable them to better care for the 7% of patients on the practice list who were diabetic.
- 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 and nurse forums both within the locality and those hosted by AT Medics.

- 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 for the pharmacist and practice nurse and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. GPs received an internal review from one of the senior GPs in addition to their external appraisal.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating 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 plans, medical records and investigation and test results.
- From the 23 documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis both within the practice and locality and care plans were routinely reviewed and updated for patients with complex needs on the basis of discussions.

Are services effective?

(for example, treatment is effective)

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

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. Patients who had joint injections provided signed written consent which was stored on patient's records.
- 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.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

- The practice offered in house smoking cessation and patients could be referred to a dietician for advice and support with weight management if required.

The practice's uptake for the cervical screening programme was 76%, which was comparable with the CCG average of 74% and the national average of 76%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. The practice had exceeded the target of 90% for both primary and booster immunisations in 2016/17.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems 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.

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.

Are services caring?

Our findings

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 17 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with 10 patients including one member of the patient participation group (PPG). All but one patient told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 96% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%

- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local average of 82% and the national average of 86%.
- 85% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 91%.
- 94% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 94% and the national average of 97%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local average of 85% and the national average of 91%.
- 89% of patients said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 87%.

Only one score was below national averages:

- 79% of patients said the nurse gave them enough time compared with the CCG average of 87% and the national average of 92%.

As a result of this feedback the practice had made all nursing appointments 15 minutes long and the practice nurse had additional slots which enabled her to catch up if appointments overran. .

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

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

Are services caring?

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 82% of patients said the last GP they saw was good at involving them in decisions about their care compared to the local average of 87% and the national average of 82%.
- 84% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 90%.
- 75% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the local average of 79% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

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. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 70 patients as carers (1% of the practice list). The practice held a carers event in February 2017 where they had identified an additional 11 carers. Regular coffee mornings were also held throughout the year and the practice had invited a member of a local caring support organisation to attend to provide advice to those who attended. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support including referrals to a local support service which aimed to ensure that older patients were able to maintain quality of life and independence. In addition all carers were offered an annual health check and flu vaccination. Fifty two percent of carers had received an annual flu vaccine in the previous year.

A member of the practice reception team acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

Staff told us that if families had experienced bereavement, their usual GP contacted them and sent them a condolence card. 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population. For example the practice participated in a locality wide initiative delivering holistic health assessments to patients over 65 who were housebound or who had not attended the practice in 18 months and for all patients over the age of 80 years old. The aim of the assessment was to develop a care plan which addressed both the health and social needs of these patients through provision of support by the practice, other healthcare organisation and agencies in the voluntary sector.

- The practice offered extended hours on a Monday and Thursday evening until 8 pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- The practice was accessible to those with mobility difficulties with all consultation rooms being located on the ground floor of the practice.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice offered a telephone consultation service and consultations using email. Patients could book appointments online and access their medical records. The practice actively promoted online services and had a comparatively high uptake comparative to other practices in the CCG.

Access to the service

The practice was open Monday to Friday. Opening hours were between 8 am till 8 pm Mondays and Thursdays. The practice closed at 6.30 pm the rest of the week. Appointments were available during these times. Extended hours appointments were offered between 6.30 pm and 8 PM Monday and Thursday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. Patients who required urgent care could also be booked by the practice into the local extended access service which was open seven days per week from 8 am to 8 pm.

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

- 76% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 74% and the national average of 76%.
- 91% of patients said they could get through easily to the practice by phone compared to the local average of 74% and the national average of 71%.
- 85% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 82% and the national average of 84%.
- 81% of patients said their last appointment was convenient compared with the CCG average of 75% and the national average of 81%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 69% and the national average of 73%.
- 49% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 51% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

Are services responsive to people's needs?

(for example, to feedback?)

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

- We saw that information was available to help patients understand the complaints system. A complaint leaflet was available at the reception desk.

We looked at eight complaints received in the last 12 months and found that responses were issued in reasonable time frames and contained apologies and detailed information of action taken by the practice to resolve concerns raised. Lessons were learned 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, a complaint had been received at the practice regarding the referral process. The GP team reviewed the process for making referrals and the administrative team received training on how to better explain the referral process to patients.

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 accessible care and promote good outcomes for patients.

- The practice had a list of objectives which was displayed in the waiting areas and staff knew and understood these.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

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 and ensured that:

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

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. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with health visitors to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- There was a strong focus on learning and development within AT Medics. Staff at all levels of the organisation had the opportunity to learn and develop. The practice offered either face to face or web based training for staff working in all sections of the practice including bi

Are services well-led?

Good 

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

monthly face to face support for practice managers and clinicians and web based training for administrative staff. The practice had trained their phlebotomist to become a healthcare assistant. GPs in the practice had recently received accreditation to enable the practice to become a training practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought 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, one of the main issues of concern identified by patients and the PPG was the practice's previous premises. The PPG had given advice on how to ensure that all patients were aware of the move including notifying local organisations including housing associations. In response to feedback from patients about appointments running late the practice had changed appointment times to address this concern.
- The NHS Friends and Family test, complaints and compliments received. In response to feedback received through the friends and family test the practice launched a "continuity of care campaign" which aimed to ensure all patients had access to their own GP for routine appointments and changed their clinic timetable in an effort to reduce waiting times.

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

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. AT Medics had created a digital software tool which ensured effective governance and oversight across all AT Medics sights. The system recorded all staff training and monitored the expiry dates clinical staff's professional registrations. Searches were regularly run at the practice which highlighted staff who required training or which professional registrations needed to be checked. The system also enabled the practice pharmacist to ensure compliance with medicines safety alerts and that patient medicines were optimised in accordance with current best practice. In addition the practice used the software to analyse patient data to ensure those with long term conditions were identified, coded and called in for periodic reviews. As a result of the software's analysis which looked at risk factors and patient medicines, the practice increased the number of patients on their asthma register by 29% and those on their pre diabetic register by 118% between April 2016 and August 2017. The software had also been used to generate information used for an audit of diabetic patients which show a significant increase in patients who had blood sugar levels within the optimal range.