Prospect Medical Group

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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Prospect Medical Practice on 13 October 2015. Overall, the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses;
- Risks to patients and staff were assessed and well managed;
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and responsibilities;
- 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;
- Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Results from the national GP Patient Survey showed patients were satisfied with the quality of the care and treatment they received from their GPs and nurses;
- Most patients expressed no concerns about access to appointments. Whilst the practice performed well in most areas covered by the survey, their performance fell considerably below that of the local Clinical Commissioning Group (CCG) and national averages in relation to telephone access to the practice, access to appointments, and appointment waiting times. We found the practice was aware of this and were constantly adjusting the resources they had available to them to make their telephone and appointment system more responsive;
- There was a clear leadership structure and staff felt supported by the management team. Good governance arrangements were in place;
- Staff had a clear vision for the development of the practice and were committed to providing their patients with good quality care.

We saw several areas of outstanding practice including:

Summary of findings

- The practice had also collaborated with a local advocacy service, and representatives of local black and ethnic minority communities, to produce a leaflet to help patients understand how to use the services provided by the practice;
- Over 50% of patients registered with the practice were people whose first language was not English. We saw the practice had taken steps to make their service accessible to this group of patients. For example, 1387 interpreter sessions had been arranged during the previous six months. Reception staff also had access to prompt sheets in some languages, to help them assist patients to explain their reasons for attending the practice. Work was underway to extend the range of languages covered by the prompt sheets. Staff were in the process of setting up a system to translate standard practice letters into a range of other languages to help promote better patient communication. A facility on the practice's website enabled patients to obtain translations of each web page in a language of their choice. The practice had recruited two GPs who spoke some of the Indian Sub-Continent languages. The arrivals screen provided patients with information in a range of languages. The practice did not have a hearing loop system, but steps were being taken to have one installed. Information on the practice website informed patients that they could book an interpreter by contacting reception staff. Reception staff were clear about the arrangements for accessing interpreters and we saw this happen during the observation we carried out in the reception area.

The areas where the provider should make improvements are:

- Complete fire drills at the frequency outlined in the practice's fire risk assessment;
- All staff who undertake chaperone duties should receive appropriate training;
- Develop a more proactive and structured approach to identifying topics for clinical audit;
- Continue to monitor and review the effectiveness of the practice's appointment system to ensure it remains responsive to patients' needs.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned when things went wrong and shared with staff to support improvement. There was an effective system for dealing with safety alerts and sharing these with staff. Individual risks to patients had been assessed and were well managed. Good medicines management systems and processes were in place and staff recruitment was safe. The premises were clean and hygienic and there were good infection control processes. However, staff had not taken part in fire drills for over five years. Also, some staff who acted as chaperones to patients had not completed training to help them carry out this role safely and effectively.

Are services effective?

Good

The practice is rated as good for providing effective services. Nationally reported Quality and Outcomes Framework (QOF) data showed the practice had performed well in providing recommended care and treatment to their patients. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health, and providing advice and support to patients to help them manage their health and wellbeing. Staff worked with other health care professionals to help ensure patients' needs were met. There was an effective staff appraisal system and, overall, staff had access to the training they needed to carry out their duties. Staff had completed a variety of clinical audits and used these to improve patient outcomes. However, we found the practice's approach to selecting areas for clinical audit tended to be reactive rather than the clinical team proactively identifying a programme of audits to improve outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Results from the National GP Patient Survey showed patients were satisfied with the quality of the care and treatment they received from their GPs and nurses. During the inspection we saw staff treating patients with kindness and respect, and they maintained patient confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Staff had reviewed the needs of their local population and were providing services to meet them. The practice was engaged with the local Clinical Commissioning Group (CCG) and worked with them to improve and develop patient care in the locality within which they were based. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available. Action had been taken to help patients whose first language was not English to understand the services available to them at the practice and how they could access these. This included working with local organisations and representatives of local ethnic minority groups, to facilitate access to services at the practice. Further work was underway to make information available in a wider range of languages, to take account of the needs of their patient population, and to support staff to work more effectively with patients from ethnic minority groups.

Most patients who completed Care Quality Commission (CQC) comment cards raised no concerns about access to appointments. However, all six patients we spoke with expressed some degree of dissatisfaction about delays in getting through to the practice by telephone as well as difficulties in obtaining an appointment. Whilst the practice performed well in most areas covered by the National GP Patient Survey, their performance fell considerably below that of the local CCG and national averages in relation to access to the practice, access to appointments, and appointment waiting times. At the time of the inspection, staff were taking action to address these issues.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff had a clear vision about how they wanted the practice to grow and develop, and were taking steps to deliver this. The practice had good governance processes, and these were underpinned by a range of policies and procedures that were accessible to all staff. There were systems and processes in place to identify and monitor risks to patients and staff, and to monitor the quality of services provided. Regular practice and multi-disciplinary team meetings took place, which helped to ensure patients received effective and safe clinical care. The practice proactively sought feedback from patients who were encouraged and supported to comment on how services were delivered.

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. Staff provided proactive, personalised care which met the needs of older patients. Patients aged 75 and over had been allocated a named GP to help ensure their needs were met. Arrangements had been made to meet the needs of 'end of life' patients. For example, staff held monthly palliative care meetings with other healthcare professionals to review and ensure these patients' needs were met. The practice participated in the local Clinical Commissioning Group's (CCG) Care Homes Project and acted as the link practice for two care homes. Weekly visits were undertaken to these homes and residents registered with the practice had individual care plans. The practice offered home visits and longer appointment times where these were needed by older patients. Nationally reported data showed the practice had performed well in providing recommended care and treatment for the clinical conditions commonly associated with this population group.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Effective systems were in place which ensured that patients with long-term conditions received an appropriate service which met their needs. Nationally reported data showed the practice had performed well in providing recommended care and treatment for the clinical conditions commonly associated with this population group.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. For example, patients were able to access weekly 'drop-in' sessions with a health visitor as well as a baby clinic advice service. The practice routinely met over 90% of their immunisation targets. Younger patients were able to access contraceptive and sexual health services, and appointments were available outside of school hours. Monthly child protection meetings took place between the practice's safeguarding lead and attached health visitors and midwives. There were systems in place to identify and follow up children who were at risk.

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 practice was

proactive in offering online services, as well as a full range of health promotion screening that reflected the needs of this age group. Late appointments, until 8pm, were offered twice weekly, to make it easier for families and working-age patients to obtain convenient appointments. Nationally reported data showed staff were good at providing patients with the recommended care and treatment for all but one of the clinical conditions covered by the QOF such as coronary heart disease and hypertension.

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. For example, the practice maintained a register of patients with learning disabilities and offered annual reviews to help them stay healthy. Nationally reported data showed the practice had performed well in providing recommended care and treatment to patients with learning disabilities. Systems were in place to protect vulnerable children. For example, staff 'flagged' the records of at-risk children to identify when the practice had been contacted about these patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. They also understood their responsibilities regarding information sharing and the documentation of safeguarding concerns. Patients requiring palliative care (and those nearing the end of their lives) were given the mobile and home telephone numbers of their GP, for use in an emergency. These patients had also been sent a letter informing them that if they contacted the practice between 10am and 1pm, they would be guaranteed a telephone call from one of the GPs.

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). Nationally reported data showed the practice had performed well in providing recommended care and treatment to patients with mental health needs. Patients experiencing poor mental health were provided with advice about how to access various support groups and voluntary organisations, and were able to access in-house counselling. The practice had an identified lead GP for mental health and dementia. Patients were provided with an annual healthcare review and the opportunity to participate in the preparation of a personal care plan. Staff were actively screening patients at potential risk of dementia. The GPs had monthly meetings with a consultant psychiatrist to discuss patients with mental health needs who were receiving care and treatment.

Summary of findings

What people who use the service say

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 34 completed comment cards and 32 respondents were positive about the standard of care and treatment provided. Words used to describe the service included: excellent; kind and compassionate; courteous, professional and thorough; treated well; always responsive; friendly and efficient. Two patients said they found it difficult to get through to the practice by telephone and obtain an appointment, and a third patient said that whilst they were satisfied with the service they received overall, they said obtaining an appointment was difficult. Most patients who commented said reception staff were helpful, however, two patients said they had not found this to be the case.

We also spoke with six patients during the inspection. Four patients made positive comments about their overall experience of using the practice. Words used to describe the practice included: reception staff are really helpful; happy; good; make you feel happy and relaxed when you leave. Where patients commented they told us: staff's attitude was good; the practice was clean and hygienic; staff respected their privacy and dignity, involved them in decisions about their care and treatment and provided information about the medicines they were prescribed. However, all six patients expressed concerns about access to appointments. Two patients told us it was difficult to get through to the practice on the telephone and when they did there were no appointments left. Three patients told us they waited two to three weeks for an appointment. One patient told us it was difficult to get an appointment. Where patients commented, they said they had to wait past their appointment times before seeing a GP or nurse. However, none said they were unhappy with this. One patient said reception staff informed you on arrival if a doctor was running late.

The national GP Patient Survey of the practice, published in July 2015, showed varying levels of patient satisfaction, with the practice performing well in some areas, and less well in others. For example, patient satisfaction was mostly above or in line with the local Clinical Commissioning Group (CCG) and national averages, with regards to the quality of care and treatment patients received from the GPs and nurses. Patient satisfaction levels in other areas covered by the survey, although below the local CCG, and in some instances the national averages, were broadly in line with these. However, there were four areas where the practice's performance was considerably below the local CCG and national averages.

Of the patients who responded to the national survey:

- 90% said their last appointment was convenient, compared to the local CCG average of 93% and the national average of 92%;
- 95% had confidence and trust in the last GP they saw, compared with the local CCG average of 96% and the national average of 95%;
- 94% said the last GP they saw or spoke with was good at treating them with care and concern, compared to the local CCG average of 87% and the national average of 85%;
- 100% said they had confidence and trust in the last nurse they saw or spoke to, compared with the local CCG average of 98% and the national average of 97%;
- 95% said the last GP they saw or spoke with was good at treating them with care and concern, compared to the local CCG average of 92% and the national average of 90%;
- 62% said they usually get to see or speak to their preferred GP, compared to the local CCG average of 61% and the national average of 60%;
- 87% said the last GP they saw or spoke to was good at giving them enough time, compared to the local CCG average of 89% and the national average of 87%;
- 88% said the last GP they saw or spoke to was good at listening to them, compared to the local CCG and national averages of 89%.

However, there were also areas were the practice's performance fell considerably below that of the local CCG and national averages. Of patients who responded to the survey:

- 77% of patients found receptionists at the surgery helpful, compared to the local CCG and national averages of 87%;

Summary of findings

- 55% said they found it easy to get through on the telephone, compared to the local CCG average of 78% and the national average of 73%;
- 55% described their experience of making an appointment as good, compared with the local CCG average of 74% and the national average of 73%;
- 37% patients said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 68% and the national average of 65%.

(382 surveys were sent out. There were 108 responses which was a response rate of 28%.)

Areas for improvement

Action the service SHOULD take to improve

- Complete fire drills at the frequency outlined in the practice's fire risk assessment;
- All staff who undertake chaperone duties should receive appropriate training;
- Develop a more proactive and structured approach to identifying topics for clinical audit;
- Continue to monitor and review the effectiveness of the practice's appointment system to ensure it remains responsive to patients' needs.

Prospect Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** A second inspector was shadowing the inspection as part of their induction. The team included a GP specialist adviser. There was also a general practice professional.

Background to Prospect Medical Group

Prospect Medical Practice is a large teaching practice providing care and treatment to patients of all ages, based on a General Medical Services (GMS) contract. The practice is situated close to the centre of Newcastle-upon-Tyne and is directly opposite the Newcastle General Hospital. The practice is part of the NHS Newcastle and Gateshead Clinical Commissioning Group (CCG). The practice provides services to approximately 15210 patients. They are based at 501 Westgate Road, Newcastle-upon-Tyne, NE4 8AY. We visited this location as part of the inspection.

The health of people who live in Newcastle is variable when compared to the England average. Deprivation is higher than average with about 13200 (29%) of children living in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 11.9 years lower for men and 9.1 years lower for women in the most deprived areas of Newcastle. A significant proportion of the practice's patients are from the Black Minority Ethnic (BME) population.

Prospect Medical Practice is located in a purpose built health centre and provides patients with fully accessible treatment and consultation rooms. All consultation and examination rooms are on the ground floor. There is a lift to the first floor should patients need to access this area for treatment. There is on-site parking, including disabled parking, a disabled WC, and wheelchair access. The practice provides a range of services and clinics including, for example, services for patients with asthma and heart disease. There are nine GP partners (three male and six female), a practice manager and assistant practice manager, a nurse manager, two practice nurses, two healthcare assistants, and a team of administrative and reception staff. A GP registrar was on placement at the practice at the time of our visit.

The practice was open on Monday and Wednesday between 8:30am and 8pm, and on a Tuesday, Thursday and Friday between 8:30am and 6pm. Appointment times were: Monday and Wednesday between 8:30am and 7:30pm; Tuesday, Thursday and Friday between 8:30am and 5:50pm. When the practice is closed patients can access out-of-hours care via the Northern Doctors Urgent Care service, and the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. This 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.

Detailed findings

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 Care Quality Commission (CQC) at that time.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)

The inspection team:

- Reviewed information available to us from other organisations, for example, NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 13 October 2015.
- Spoke to staff and patients.
- Looked at documents and information about how the practice was managed.
- Reviewed patient survey information, including the NHS GP Patient Survey.
- Reviewed a sample of the practice's policies and procedures.

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local clinical commissioning group (CCG). We carried out an announced visit on 13 October 2015. During our visit we spoke with a number of staff, including four GPs, the practice manager, the practice nurse, and staff working in the administrative and reception team. We also spoke with six patients. We observed how patients were being cared for and reviewed a sample of the records kept by practice staff. We reviewed 34 Care Quality Commission (CQC) comment cards in which patients shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included significant event reports, safety alerts and complaints. The patients we spoke with raised no concerns about safety at the practice.

There was an open and transparent approach to reporting and recording significant events. Staff had recorded 15 significant events between April 2014 and September 2015. We were told that any incident raised by a member of the team would be investigated by the practice manager, and then reviewed by clinicians at the daily practice meetings, weekly GP partners' meetings, and monthly educational meetings. Staff told us actions would be agreed to prevent a reoccurrence of the incident and a nominated person would be identified to ensure these were carried out. Annual multi-disciplinary team meetings were held to review any significant events that had occurred, so that any patterns or themes could be identified. We looked at a sample of the records of significant events and these showed they had been dealt with appropriately. Where appropriate, staff had also reported these incidents to the local Clinical Commissioning Group (CCG) via the Safeguard Incident and Risk Management System (SIRMS). (This system enables staff to flag up any issues, via their surgery computer, to a central monitoring system so that the local CCG can identify any trends and areas for improvement.) Copies of significant event review forms could be easily accessed by staff on the practice's intranet system.

Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The nurse manager said staff were encouraged to report errors so that lessons could be learnt. They gave us with an example which demonstrated the learning that had taken place, following an incident they had reported. The significant event form that had been completed was very detailed and the nurse manager confirmed the learning from this had been shared with the rest of the team. However, none of the GPs we spoke with were clear about which notifications would need to be made to the Care Quality Commission (CQC) and other relevant organisations. They told us the practice manager would have this information and we were able to confirm that this was correct.

The practice had appropriate systems for handling safety alerts, including medicines alerts. All safety alerts were distributed to staff via the practice's clinical IT system. We were told a designated member of staff then identified what action, if any, needed to be taken and by whom. However, staff did not keep a central log of the safety alerts they had actioned and completed.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices which helped to keep patients safe.

For example, arrangements had been made to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The practice had accessible safeguarding policies and procedures. The nurse manager we spoke with was able to locate an up-to-date copy of the practice's safeguarding policy when requested. Key safeguarding contact numbers were available on the practice's intranet and displayed on staff noticeboards. Two of the GP partners acted as the safeguarding leads for the practice and provided advice and guidance to other staff where this was necessary. The practice manager confirmed all of the GPs had completed Level 3 child protection training and the nurses had completed Level 2. However, they told us they needed to obtain documentary evidence that their salaried GP had completed the necessary training. All staff had also recently received adult safeguarding training provided in-house by an external facilitator. Staff demonstrated they understood their responsibilities. Systems were in place which helped to ensure that at-risk patients were identified in the patient clinical records system. This helps to make sure all clinical staff are aware of which patients are considered to be vulnerable;

Posters were displayed in the patient waiting area, and in consultation rooms, advising patients that they could request a chaperone. All staff who acted as chaperones had undergone 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 and adults who may be vulnerable.) However, some clinical staff who undertook chaperoning duties had not completed training for this role;

Good

Are services safe?

There were procedures for monitoring and managing risks to patient and staff safety. Overall, we found that appropriate checks were carried out to ensure the premises, and the equipment used by staff, were maintained in a safe condition. Staff had carried out an environmental health risk assessment in August 2014 to help identify and minimise risks to staff and patients. For example, staff were taking steps to address the potential risks from window blinds that had loop cords. A further audit had been planned for October 2015. All the electrical equipment had been tested during the previous 12 months to ensure it was safe to use and in good working order. The sample of records we looked at confirmed appropriate testing of clinical equipment had taken place. A fire risk assessment had been carried out in April 2012 to help staff identify and manage potential fire risks. However, this risk assessment had not been reviewed for over 12 months. The practice had a designated fire safety lead and the practice manager told us there fire wardens on each floor of the premises. Although suitable arrangements had been made to provide staff with fire safety training, they had not taken part in a fire drill for over five years. Carrying out regular fire drills helps ensure staff understand what to do if there is a fire;

Appropriate standards of cleanliness and hygiene were in place. The practice was clean and tidy throughout. Although some of the carpets in non-clinical areas were marked and beginning to show their age. We were told a replacement programme was in place to deal with this. We saw evidence of a structured and managed approach to maintaining cleanliness within the practice. For example, daily cleaning was carried out by staff working to a documented cleaning schedule. The practice had a designated infection control lead who provided staff with guidance and advice when appropriate. However, this person had not completed the more advanced training needed to enable them to carry out this lead role effectively. An infection control risk assessment had been completed in August 2014, and staff had also carried out an infection control audit in February 2015. This audit specified the actions that needed to be taken to reduce the risk of the spread of infection. We saw evidence these actions had been completed. There were infection control protocols in place and all staff had received basic infection control training. Appropriate arrangements were in place to manage any needle stick injuries. The practice carried out regular monitoring for the risk of legionella. (Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.) A legionella risk assessment had been completed, and regular water temperature checks were undertaken;

The arrangements for managing medicines, including emergency drugs and vaccines, were satisfactory. For example, we saw evidence which confirmed that medicine reviews were appropriately carried out. Reception staff we spoke with were aware of the steps they needed to take to ensure that requests for repeat prescriptions were safely handled and in line with the practice's policy. Staff confirmed that repeat prescription requests were authorised by a GP before being given to the patient, or sent electronically to their preferred pharmacy. Prescription forms were kept secure and staff were complying with relevant guidance.

Staff worked with local CCG pharmacy staff to monitor their prescribing practice, to help ensure they were following prescribing guidelines. Appropriate arrangements had been made to monitor the medicines that the GPs carried in their 'Doctor's Bag'. We checked some of these, and found the medicines carried were appropriate and all within their expiry dates.

Arrangements had been made to monitor vaccines. This included carrying out daily temperature checks of the medicines stored in the vaccine refrigerators and keeping a record of these in log books. The records we looked at showed the temperature for one of the refrigerators had, on several occasions, been recorded as being +9 degrees, which is just above the recommended temperature range. (Vaccines need to be stored at between +2 and +8 degrees Celsius to ensure their efficacy.) The nurse manager told us these records were routinely monitored, and said action would be taken to deal with this issue if it became a regular occurrence. We also saw that staff had placed a plastic box in one of vaccine refrigerators so that samples of swabs and urine could be stored in it. We mentioned this to the nurse manager who told us they would take immediate action to ensure that these samples were not stored in the vaccine refrigerators.

Satisfactory arrangements had been put in place which ensured required staff recruitment checks were carried out. The staff files we sampled showed that appropriate checks had been undertaken on the members of staff prior to their employment. These included: checks that staff were registered with the appropriate professional body;

obtaining references from previous employers; checking that staff had obtained the qualifications they needed to carry out their roles and responsibilities; carrying out a DBS check to make sure, where appropriate, new staff were safe to care for vulnerable adults and children.

The arrangements for planning and monitoring the number and mix of staff required to meet patients' needs were satisfactory. There was a rota system for all the different staffing groups to help ensure there were enough staff on duty at all times. Changes had recently been made to the administrative team rota, to ensure there were suitable staffing levels during periods of increased demand. The GP partners covered each other's leave, and, where this was not possible, the practice used ex-GP registrars as locum staff. Reception staff told us they covered all reception and administrative roles, to ensure they all knew how to carry out each other's duties.

Arrangements to deal with emergencies and major incidents

Staff had made arrangements to deal with emergencies and major incidents. For example, the practice's intranet system included a facility which enabled staff to alert others in the event of an emergency. Reception staff had access to a panic button in case they needed to get help in an emergency. A designated member of the nursing team was responsible for monitoring the availability of emergency medicines and ensuring they were within their expiry dates. A system was also in place which ensured staff carried out regular checks of the practice's resuscitation equipment, including the defibrillator and oxygen supply. The sample of records we looked at confirmed this. All staff had received basic life support training, to help them respond appropriately in an emergency. The practice had an up-to-date business continuity plan to help them manage major incidents. A copy of the plan was kept on the premises and key staff also had an electronic copy, so they could respond promptly and appropriately to an emergency when they were not at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Staff carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. They used these guidelines to develop how care and treatment was delivered to meet patients' needs. The practice used an information management system and monthly clinical educational meetings to help them keep up to date with changes in protocols and guidelines. However, when we asked the GPs we interviewed to show us where practice protocols were kept, none were able to do so. They said the practice manager would know where these were kept and provide them with access to these as and when needed. We spoke to the practice manager who was immediately able to provide us with access to the protocols. Nursing staff were easily able to access e-templates to record the outcome of the consultations they held with patients. All of the GPs were notified individually of any changes to NICE guidelines, and they met as a group to agree how to respond to these.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF) scheme. (This is intended to improve the quality of general practice and reward good practice). Staff used the information collected for the QOF and their performance against national screening programmes, to monitor outcomes for patients. Overall, the QOF data, for 2013/14, showed the practice had performed well in obtaining 97.3% of the total points available to them. (This was 1% above the local Clinical Commissioning Group (CCG) average and 3.8% above the England average.) For example, with regards to specific clinical conditions the QOF data showed:

- Performance for the cancer related indicator was better than the local CCG average (0.2% higher) and the England average (4.5% higher);
- Performance for the chronic obstructive pulmonary disease related indicator was better than the local average CCG (3.2% higher) and the England average (4.6% higher);
- Performance for the hypertension related indicator was better than the local CCG average (6.5% higher) and England average (11.6% higher).

The data showed the practice had obtained 91.1% of the total points available to them for delivering care and treatment aimed at improving public health. However, this achievement was 5.1% below the local CCG average and 3.5% below the England average. The practice had met the QOF targets for delivering recommended care and treatment in such areas as cervical screening, child health surveillance, contraception and maternity services. But, had performed less well in relation to the following: blood pressure, smoking and cardiovascular disease. For all three targets, the practice fell below both the local CCG and England averages. The information we looked at before the inspection did not identify that the practice was an outlier for any QOF (or other national indicators) with the exception of the ratio of reported versus expected prevalence for Coronary Heart Disease (CHD.) We discussed this with the clinical team, and, on the basis of the information they gave us, the inspection team decided there were no concerns regarding this finding.

The practice's clinical exception reporting rate was 9.7% for 2013/14. This was 2.8% above the CCG average and 1.8% below the England average. This suggests that the practice operates an effective patient recall system where staff are focussed on following patients up and contacting those who do not attend planned healthcare reviews. (The QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect).

Staff had carried out clinical audits to help improve patient outcomes. Those we looked at included, for example, whether the GPs were following NICE guidelines regarding the care and treatment provided to pregnant women who had been diagnosed as having diabetes. This two-cycle audit clearly identified improvements which had been made as a consequence of carrying out the audit. Other two-cycle audits had been completed, for example: the use of anti-epileptic medicines; antibiotic prescribing; dermatology referrals; patients prescribed ferrous sulphate as repeat medication; the use of antibiotics in urinary tract infections. The practice also participated in the local CCG's practice engagement programme. As part of this, they

audited referrals made for varicose veins, tonsillectomy and carpal tunnel syndrome, to see if they fell within the individual funding requirements. However, we found that the practice's approach to selecting areas for clinical audit tended to be reactive rather than the clinical team proactively identifying a programme of audits to improve outcomes for patients. We shared this feedback with staff who responded positively and agreed to review how they carried out clinical audits.

Effective staffing

Staff had the skills, knowledge and experience needed to deliver effective care and treatment. This included new staff receiving appropriate inductions. There was a specific induction pack for locum GPs to help make sure they understood the practice's systems, policies and procedures.

Staff had received the training they needed to carry out their roles and responsibilities, including training in basic life support and infection control. The nursing team had completed a range of training to help them improve the delivery of care to patients with long-term conditions. For example, the nurse manager had qualified as an independent nurse prescriber and had recently completed a training course in respiratory care. One of the nurses had completed post-graduate training in diabetes care, and another had completed an accredited course in chronic disease management. Other members of the nursing team were undertaking a course of study on delivering Well Women services and contraception, and one nurse was due to commence training in providing asthma care. Members of the healthcare assistant team had either completed or were undertaking training relevant to their roles and responsibilities. The nurse manager confirmed arrangements were in place which ensured that staff completed relevant training updates. They also told us they were able to access clinical supervision both within and outside the practice. The mandatory training needs of all staff had been identified and there was evidence that this was delivered via a programme of on-line training, and through 'Time-in/Time-out sessions held at the practice and externally. There were arrangements in place for staff to have an annual appraisal, and the GP staff were supported to work towards their re-validation with the General Medical Council.

Coordinating patient care and information sharing

The practice's patient clinical record and intranet systems helped make sure staff had the information they needed to plan and deliver care and treatment. The information included patients' medical records and test results. All documents relating to patients were scanned onto the practice's e-clinical record system and then any tasks that required completion were assigned to a GP. We were told clinical staff operated a 'buddy' system to help ensure that tasks were actioned in each other's absence. An agreed process was also in place which ensured that appropriate action was taken by the right member of staff, in relation to any electronic patient information received by the practice.

Staff worked well together, and with other health and social care professionals, to assess and plan ongoing care and treatment, and to meet the range and complexity of patients' needs. Communication between the clinical team and the community health team was good and this was made easier because they were based in the same building. All community health staff, including counsellors, psychologists, district nursing and health visitor staff, used the same IT system as practice staff which facilitated the sharing of patient information. Agreed systems were in place for clinical staff to make referrals to community health staff. Satisfactory arrangements were in place which ensured effective communication between the practice and the local out-of-hours service.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of the legislation and guidance, including the Mental Capacity Act (MCA, 2005). The patient clinical system provided staff with prompts to consider when carrying out a consultation with, for example, any patient aged under 16. The nurse we interviewed demonstrated an understanding of consent issues, especially in relation to treating patients with learning disabilities. All staff had completed training in the use of the MCA.

Health promotion and prevention

Patients had access to appropriate health assessments and checks. For example, arrangements had been made to provide women with access to cervical screening services. The QOF data showed the practice had obtained 100% of the overall points available to them for providing cervical screening services. (This was 1% above the local CCG

Good

Are services effective?

(for example, treatment is effective)

average and 2.5% above the England average). The data also showed the practice had protocols that were in line with national guidance. This included protocols for the management of cervical screening, and for informing women of the results of these tests.

Nationally reported QOF data, for 2013/14, showed the practice had obtained 88.1% of the overall points available to them for providing recommended care and treatment to patients who smoked. (However, this was 6.6% below the local CCG average and 5.6% below the England average). The data also confirmed the practice had supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy.

The practice had obtained 100% of the QOF points available to them for providing recommended care and treatment to patients with learning disabilities. (This was 9.5% above the local CCG average and 15.9% above the England average). The practice had also obtained 100% of the QOF points available to them for providing recommended care and treatment to patients with mental health needs. (This was 7.6% above the local CCG average and 9.6% above the England average). The data showed that 95.3% of patients with the mental health conditions covered had a comprehensive care plan in place, which had been agreed with them and their carers. (This was 11.6% above the local CCG average and 9.4% above the England average).

The practice offered a full range of immunisations for children at their child health and immunisation clinic. On the basis of the nationally reported data available to the Care Quality Commission (CQC), we saw that, where comparisons allowed, the delivery of the majority of childhood immunisations was just below, when compared to the overall percentages for children receiving the same immunisations within the local CCG area. However, most of the immunisation rates were above 90%. Influenza vaccination rates for patients over 65 years of age, and patients in at risk groups, were similar to those of other local practices.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection we observed that members of staff were courteous and helpful to patients who attended the practice or contacted it by telephone. We saw that patients were treated with dignity and respect. Privacy screens or curtains were provided in consulting and treatment rooms so that patients' privacy and dignity could be maintained during examinations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Background music was played in the waiting area which made it difficult for patients to overhear conversations at the reception desk. Patients who were waiting were also encouraged to stand back from the reception desk. Staff told us that a private space would be found if patients indicated they needed to discuss a confidential matter.

As part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 34 completed comment cards and 32 of the respondents were positive about the standard of care they received. Words used to describe the service included: excellent; kind and compassionate; courteous, professional and thorough; treated well; always responsive; friendly and efficient. Where patients commented, they said they were treated with respect, dignity and compassion.

Feedback from the national GP Patient Survey of the practice, published in July 2015, indicated patient satisfaction levels were mostly above, or broadly in line with, the local Clinical Commissioning Group (CCG) and the national averages with regards to how caring staff were during GP and nurse consultations. For example, of the patients who responded to the survey:

- 95% said they had confidence and trust in the last GP they saw, compared to the local CCG average of 96% and the national average of 95%;
- 94% said the GP was good at listening to them, compared to the local CCG average of 90% and the national average of 89%;
- 94% said the GP gave them enough time, compared to the local CCG average of 88% and the national average of 87%;
- 93% said the last GP they spoke to was good at treating them with care and concern, compared to the local CCG average 87% and the national average of 85%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with, and those who completed CQC comment cards and had commented on this, told us clinical staff involved them in making decisions about their care and treatment. Those that were taking medication also confirmed they had received appropriate information about the medicines they had been prescribed.

Results from the national GP Patient Survey of the practice showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The results for both the GPs and the nurses were mostly above, or broadly in line with, the local CCG and national averages. Of the patients who responded to the survey:

- 91% said the last GP they saw was good at explaining tests and treatments, compared to the local CCG average of 89% and the national average of 86%;
- 85% said the last GP they saw was good at involving them in decisions about their care, compared to the local CCG average of 84% and the national average of 81%;
- 88% said the last nurse they saw was good at explaining tests and treatments, compared to the local CCG average of 91% and above the national average of 90%;
- 88% said the last nurse they saw was good at involving them in decisions about their care, compared to the local CCG average of 87% and the national average of 85%.

Patient and carer support to cope emotionally with care and treatment

Notices displayed in the patient waiting room told patients how to access a range of support groups and organisations. The practice maintained a carers' register and their IT system alerted clinical staff if a patient was also a carer, so this could be taken into account when planning their care and treatment. Written information was available for carers to ensure they understood the various avenues of support available to them, although we felt this was limited. However, we did not see any information about bereavement services available to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to provide flexibility, choice and continuity of care. For example:

- Patients aged over 75 years of age and patients with long-term conditions had been allocated a named doctor, and had been informed of this in writing. The practice was able to demonstrate good Quality and Outcomes Framework (QOF) performance for the conditions covered by the scheme affecting these group of patients. Staff participated in the local Clinical Commissioning Group's 'Care Home Project', and had agreed to act as the link GP practice to two local care homes. The GPs carried out weekly visits to these homes and patients registered with the practice had individual care plans. Another example of the practice developing services to meet the needs of these groups of patients was the provision of easier access to medical support. In addition, all housebound patients had been identified and arrangements were in place to provide them with access to an annual review;
- The needs of patients with long-term conditions were managed by the nursing team, and staff maintained a register of these patients to help them plan, and deliver, appropriate services to meet their needs. The nurse manager had developed protocols for each type of long-term condition, to help ensure patients received a timely invitation to attend for their annual healthcare review. Staff had access to comprehensive protocols for annual reviews and dealing with exacerbations in patients' health. We were shown an exacerbation pathway which involved nursing staff following up patients who had an experienced deterioration in their health. They had also developed self-management plans to help patients manage their conditions.

A range of other specialist services were provided including, for example: clinics for patients with asthma and diabetes; combined clinics for patients with a range of long-term conditions, such as chronic kidney disease and heart failure. We were shown standardised templates which nursing staff used to record the outcome of their assessments, as well as any agreements reached with patients about how to manage their long-term conditions.

Staff had taken steps to make it easier for patients with long-term conditions to access healthcare reviews. For example, they carried out tests on patients during their initial health appointment, and arranged follow up appointments where they focussed on health promotion and self-management. Staff were participating in the 'Ways to Wellness' programme, which is aimed at supporting patients with long-term conditions living in socially deprived areas to manage their lives better, feel less isolated and live longer. The practice was able to demonstrate good QOF performance for most of the long-term conditions covered by the scheme. There were designated lead clinicians for each type of long-term condition which helped to make sure staff had access to appropriate clinical leadership;

- Staff had taken steps to develop services to meet the needs of children, families and young people. For example, staff told us they had developed good working relationships with other staff based in the healthcare centre, such as midwifes and health visitors. Patients were able to access weekly health visitor 'drop-in' sessions and a baby clinic advice service. The practice routinely met over 90% of their child immunisation targets. Staff understood the importance of obtaining immunisation histories for children. They told us this helped to ensure that children received the right vaccinations at the right time. Young people were able to access contraceptive and sexual health services, and appointments were available outside of school hours. We were told that patients requesting same day appointments for children would always be seen on the day. Monthly child protection meetings took place between the practice's safeguarding lead and attached health visitors and midwifes;
- The practice provided working age patients with access to extended hours appointments. Patients could book an appointment and request repeat prescriptions on-line. Telephone consultations were available, which made it easier for working patients to access GP and nurse advice. Influenza clinics were held on a Saturday during the peak season. NHS health checks for people aged 40-74 were not being provided, but patients had access to Well Women and Well Man clinics;
- The needs of vulnerable patients had been identified and services developed to meet their needs. The practice kept a list of their vulnerable patients to ensure

they knew who required extra help, support and treatment. Patients requiring palliative care (and those nearing the end of their lives) were given the mobile and home telephone numbers of their GP, for use in an emergency. These patients had also been sent a letter informing them that if they contacted the practice between 10am and 1pm, they would be guaranteed a telephone call from one of the GPs. The practice registered homeless patients and asylum seekers, and offered health checks to this group of patients. The practice had designated leads for patients with learning disabilities and for safeguarding. Staff flagged at-risk patients on the clinical IT system to ensure they were known to staff. Regular safeguarding meetings were held, and key staff had recently met with the local CCG lead to make sure their safeguarding processes were in line with local and national procedures;

- Arrangements had been made to meet the needs of patients with mental health needs. For example, the practice had a designated lead GP for mental health and dementia. Patients were provided with an annual healthcare review and the opportunity to participate in the preparation of their personal care plan. Staff had used a dementia screening tool to check that patients on their dementia register met the criteria for inclusion. Staff were also actively screening patients at potential risk of dementia. The GPs met with a consultant psychiatrist each month to discuss patients who were receiving care and treatment.

Access to the service

The practice was open Tuesday, Thursday and Friday between 8:30am and 5:50pm and Monday and Wednesday between 8:30 and 8pm. Appointment times were: Monday and Wednesday between 8:30am and 7:30pm; Tuesday, Thursday and Friday between 8:30am and 5:50pm.

Patients were able to book appointments either by telephone, online or by attending the practice. Appointments could be booked up to six weeks in advance, and bookable GP and nurse telephone consultations were also available each day. Open access appointments were offered early afternoons and on some evenings, to help meet demand from patients requesting same-day urgent appointments. We observed reception staff responding appropriately to patients and being very helpful. On arrival, patients were notified if the GP or nurse they were due to see was running late.

The majority of patients who provided us with feedback did not raise any concerns over access to appointments. However, a small number of patients told us they found it difficult to access appointments, and said they were not happy with the appointments system. Results from the national GP Patient Survey of the practice, published in July 2015, showed that patient satisfaction with the convenience of their last appointment, and practice opening hours, was broadly in line with the local CCG and national averages. However, patient satisfaction in other areas related to access to appointments were, in some cases, considerably below the local CCG and national averages. Of the patients who responded to the survey:

- 90% said the last appointment they got was convenient, compared to the local CCG average of 93% and the national average of 92%;
- 75% were satisfied with the practice's opening hours, compared to the local CCG average of 78% and the national average of 75%.

However, only:

- 55% of patients described their experience of making an appointment as good, compared to the local CCG average of 74% and the national average of 73%;
- 37% patients said they usually waited 15 minutes or less after their appointment time, compared to the local CCG average of 68% and the national average of 65%;
- 55% of patients said they found it easy to get through to the practice by the telephone, compared to the local CCG average of 78% and national averages of 73%;
- 77% of patients found receptionists at the surgery helpful, compared to the local CCG and national averages of 87%.

Practice staff were very aware of issues regarding the appointments system, and had carried out an access audit earlier in the year. Following this they had introduced a number of changes. For example, extra administrative staff had been rostered on duty from 8am to take account of increased demand. The practice had also collaborated with a local advocacy service, and representatives of local black and ethnic minority communities, to produce a leaflet to help patients understand how to use the services provided by the practice.

Over 50% of patients registered with the practice were people whose first language was not English. We saw the practice had taken steps to make their service accessible to

Good

Are services responsive to people's needs?

(for example, to feedback?)

this group of patients. For example, 1387 interpreter sessions had been arranged during the previous six months. Reception staff also had access to prompt sheets in some languages, to help them assist patients to explain their reasons for attending the practice. Work was underway to extend the range of languages covered by the prompt sheets. Staff were in the process of setting up a system to translate standard practice letters into a range of other languages to help promote better patient communication. A facility on the practice's website enabled patients to obtain translations of each web page in a language of their choice. The practice had recruited two GPs who spoke some of the Indian Sub-Continent languages. The arrivals screen provided patients with information in a range of languages. The practice did not have a hearing loop system, but steps were being taken to have one installed. Information on the practice website informed patients that they could book an interpreter by contacting reception staff. Reception staff were clear about the arrangements for accessing interpreters and we saw this happen during the observation we carried out in the reception area.

Listening and learning from concerns and complaints

The practice had a system for managing complaints. This included having a designated member of staff who was responsible for handling any complaints received. The practice brochure, which was given to new patients when they registered, contained information about how to make a complaint. It included a separate complaints and comments leaflet which provided patients with guidance about what to do if they were unhappy with how the practice had handled their complaint. However, the brochure and the complaints leaflet were only available in English. Information about how to complain was also available on the practice's website and a comments box had been placed in the reception area. However, four of the six patients we interviewed told us they did not know how to make a complaint.

The practice had received six complaints during the period between April and September 2015. We looked at a sample of these and found they had been responded to promptly and appropriately. Apologies were offered where the practice judged they had not got things right. However, in the records of one complaint, we noted there was no information in the closure letter about how the complainant could access further support, if they were unhappy with the way in which the practice had handled their concern. In the records for another, there was no evidence that a formal closure letter had been sent to the complainant.

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 about how to deliver high quality care and promote good outcomes for patients. Staff had prepared a statement of purpose which set out the aims and objectives of the practice. The interviews we carried out with staff provided evidence of a culture which was patient focussed and underpinned by effective teamwork. For example, the nursing team had agreed their own aims and objectives and the nurse team manager provided nursing staff with effective clinical support and guidance.

The partners met annually to agree plans for the development of the practice for the year ahead. Records were kept of the outcome of these meetings, but there was no formal documented business development plan. Nevertheless, the GP partners and the practice manager were able to clearly describe the arrangements they had put in place to meet the needs of their patients, and provided evidence to support this. Our interviews with GP staff showed they understood the challenges they faced and the impact of these on their day-to-day practice.

Governance arrangements

We saw evidence of good governance arrangements. The practice had policies and procedures to govern their activities and there were systems to monitor and improve quality and identify areas of risk and how to minimise these. Staff took on lead roles to help provide their colleagues with leadership, guidance and advice in the areas of responsibilities that had been delegated to them. Regular practice and multi-disciplinary team meetings took place, which helped to ensure patients received effective and safe clinical care. Arrangements had been made which supported staff to learn lessons when things went wrong, and to support the identification, promotion and sharing of good practice. The practice proactively sought feedback from patients and had a Patient Participation Group (PPG). There were good arrangements for making sure the premises, and the equipment used by staff, were maintained in a safe condition and worked satisfactorily. There was a clear staffing structure and staff understood their own roles and responsibilities. Clinical audits were carried out and staff were able to demonstrate how these led to improvements in patient outcomes. However, the inspection team felt the practice could develop a more structured approach to identifying areas for clinical audits, and for making the results of these easily accessible to staff.

Leadership, openness and transparency

The GP partners and practice manager had the experience, capacity and capabilities needed to run the practice and ensure high quality care. Staff had created a culture which encouraged and sustained learning at all levels in the practice. Through their partnership working with other agencies, they had promoted quality and continuing improvement. Staff told us the practice was well led and they said they would feel comfortable raising issues.

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

The practice encouraged and valued feedback from patients. There was an active PPG consisting of eight members. Most communication by the practice manager with members of the group was via email. The group had not met formally during 2015. We were told this was mainly because the practice manager had focussed their time on meeting with local stakeholders and representatives of local ethnic minority groups, to look at ways of encouraging patients whose first language is not English, to comment on the quality of services provided by the practice. The work of the PPG was promoted on an electronic noticeboard in the patient waiting area, in the practice's brochure and on their website. Minutes of previous meetings had been placed on the practice's website, as well as a copy of the annual survey report for the practice for the year 2014 which members of the PPG had contributed to. This report identified what could be done to improve the practice in the year ahead. The practice manager told us the action points outlined in this report were due to be reviewed shortly.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. Staff were forward thinking and committed to developing patient focussed services. For example, they were working with local stakeholders and representatives of the local ethnic minority population to promote better access for the large of patients whose first language is not English.

Are services well-led?

Good

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

The practice demonstrated their commitment to continuous learning by providing staff with access to the training they needed to carry out their role effectively, and by providing placements for GP Registrars (trainee doctors). The practice had an educational programme and there was monthly reserved time for clinicians and administrative staff to attend local training events.