

Kiltearn Medical Centre

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Kiltearn Medical Centre on 11 November 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 to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients 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 any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Information about services and how to complain was not readily available in document form once provided it was easy to understand.
- Patients said they often found it difficult to make an appointment; however there was good 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.

We saw two areas of outstanding practice:

- The practice was engaged in formal medical research and one of the GPs led this area of work, we saw that some of the research had led to new medicines being introduced nationally

Summary of findings

- The practice had a robust clinical audit regime, some of the findings from these audits had led to the best practice being identified and shared with other providers in the area

However there were areas of practice where the provider needs to make improvements.

Importantly the provider MUST:

- Review and improve access and availability of routine patient appointments.

Additionally the provider should:

- Ensure infection control training is provided for staff with specific responsibilities for this.
- Ensure that all stocks of equipment are within date for their use
- Ensure there is a robust system for checking medicines are stored at the correct temperature
- Ensure nursing staff have effective clinical supervision

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There was an effective system in place for reviewing and learning from significant events. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. Patients said they often found it difficult

Good



Summary of findings

to make an appointment; however 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 not available in the reception area, however once provided it was easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were not always clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was very active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. GPs made scheduled visits to local care homes and had built up continuity of care with the patients that lived there.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Good



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 the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of

Good



Summary of findings

care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice had established links with local colleges and met the specific needs of patients from these places.

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. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



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). Almost all people experiencing poor mental health had received an annual physical health check. The practice used both repeated letters and phone calls to remind patients to attend their reviews. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The National GP Patient Survey results published on 6 July 2015 showed the practice was mostly performing in line with local and national averages. There were 129 responses from 277 surveys sent out (a 41% return rate). Those surveyed represented 0.2% of the practice population.

- 19% find it easy to get through to this surgery by phone compared with a CCG average of 62% and a national average of 73%.
- 68% find the receptionists at this surgery helpful compared with a CCG average of 84% and a national average of 87%.
- 74% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 84% and a national average of 85%.

- 91% say the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 59% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 59% and a national average of 65%.
- 95% had confidence and trust in the last GP they saw or spoke to, compared with a CCG average of 96% and a national average of 95%.

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 mostly positive about the standard of care received. There were several adverse comments about being able to access appointments, these patients said it was difficult to make an appointment and get through on the telephone.

Areas for improvement

Action the service **MUST** take to improve

Review and improve access and availability of routine patient appointment

Action the service **SHOULD** take to improve

Ensure infection control training is provided for staff with specific responsibilities for this.

Ensure that all stocks of equipment are within date for their use

Ensure there is a robust system for checking medicines are stored at the correct temperature

Ensure nursing staff have effective clinical supervision

Outstanding practice

The practice was engaged in formal medical research and one of the GPs led this area of work, we saw that some of the research had led to new medicines being introduced nationally

The practice had a robust clinical audit regime, some of the findings from these audits had led to the best practice being identified and shared with other providers in the area

Kiltearn Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors; a GP and a Practice Manager. Our inspection team also included an expert by experience who is a person who uses services themselves and wants to help CQC to find out more about people's experience of the care they receive.

Background to Kiltearn Medical Centre

Kiltearn Medical Centre provides primary medical services to approximately 13,400 patients in the catchment area of Nantwich and surrounding rural areas. Services are provided from a purpose built building in the Nantwich town centre under a Personal Medical Services (PMS) contract. Co-located with the practice are a number of other GP practices and a pharmacy.

There are eight GPs at the practice (two male and six female), and patients can be seen by a male or female GP as they choose. There is a team of nursing staff including an advanced nurse practitioner and healthcare assistants. They are supported by a team of management, reception and administrative staff.

The practice is open between 8:00am and 6:30pm Monday to Friday. Appointments are available 8:30am to 6:30pm Monday to Friday. Extended hours surgeries are offered on Wednesday from 7:00am, on Thursday evenings until 8.00pm and from 9.00am to midday on Saturdays.

From the 1 October 2015 the practice had, in consultation with NHS England begun to use NHS 111 to access it's out of hours service so that patients had access to care when the surgery was closed.

Why we carried out this inspection

We inspected this service as part of our 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.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the 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?

Detailed findings

- 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed

information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection. We carried out an announced inspection on 11 November 2015.

During our visit we spoke with four GPs, two nurses, an advanced nurse practitioner, the Practice Manager, the Finance Manager, the Patient Experience Manager and reception staff. We also spoke with four members of the patient participation group (PPG).

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the practice.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto the system and automatically treated as a significant event. We noted that staff dealt with some minor complaints without recording them. The Practice Manager told us that all complaints however minor would be recorded in future. The practice carried out an analysis of the significant events and this also formed part of the GPs' individual revalidation process. We looked at several examples of how the practice dealt with significant events; the system was effective and used a colour coded risk matrix to ensure that the correct level of response was applied to the event.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example a recent issue relating to temperatures of fridges had led to an investigation into the potential risk this may have caused. Once risk had been assessed any immediate concerns dealt with, an action plan was agreed to prevent any further occurrences, The practice was putting new systems in place to ensure that fridge temperatures (which store temperature sensitive medicines) were, in future, more robustly monitored.

Safety was monitored using information from a range of sources, including national institute for health and care excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice could demonstrate its safe track record through having risk management systems in place for safeguarding, health and safety including infection control, medication management and staffing.

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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. Laminated posters were placed in treatment rooms and staff areas to remind staff of the process for raising concerns. We saw no posters relating to raising concerns about other members of staff (known as whistleblowing). We were told that this would be addressed. There were two lead members of staff for safeguarding (one for adults and one for children). The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff nominated as chaperones were trained for the role and had received a disclosure and barring check (DBS). These 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. Those staff not nominated as chaperones had undergone a documented risk assessment as to why no DBS check had been completed. We noted that on at least one occasion a receptionist who had not been checked on the DBS database had carried out chaperone duties. We spoke to the management team about this, who believed it was a one off incident involving a locum GP and said they would re-enforce the policy around chaperoning.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and regular fire drills were carried out. Staff we spoke with said they had been trained in fire safety, we checked training certificates that evidenced their training. Staff knew who was the appointed fire Marshalls for that day. Almost all electrical equipment was checked to ensure the equipment was safe to use, we did note that one observation lamp had not been tested since April 2011. Clinical equipment was checked to ensure it was working properly, we did note a number of plastic receptacles for blood samples had passed their expiry date. We were told that a more effective stock control system would be introduced to prevent stock from

Are services safe?

becoming out of date. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control.

- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. One of the practice nurses was the infection control clinical lead who kept up to date with best practice by on-line learning. We noted that they had not undertaken a formal training course, despite having requested one previously. The lead GP told us that courses had been difficult to identify and that they would renew efforts to locate a course suitable for a practice infection control lead. There was an infection control protocol in place and some staff had received up to date training. Annual and six monthly infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. We noted that these audits were extensive and had been effective at identifying and rectifying issues. The practice had carried out Legionella risk assessments and regular monitoring.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Some improvements were planned around the checking of fridge temperatures to ensure temperature sensitive medicines always remained within manufacturer guidelines. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.

- Recruitment checks were carried out and the four files we sampled showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book 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 fit for use. The advanced nurse practitioner told us that a better system for checking what emergency medicines were located in which areas of the practice was to be introduced.

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

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

The practice carried out assessments and treatment in line with NICE best practice guidelines and had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. We noted that the care plans we looked at were very detailed and patient centred. The practice had produced its own template to better document patient care; the method was particularly effective in planning care for patients with multiple long term conditions.

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. Patients who were on the practice register for unplanned admissions to the accident and emergency department were coded on their patient notes with a very comprehensive care plan, which includes patient details, their individual needs, evidence of recording Mental Capacity Act (MCA) issues and any issues relating to deprivation of liberty safeguards (DOLS), as well as a section on their resuscitation and future care wishes.

Protecting and improving patient health

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. A diet advice was available on the premises and smoking cessation advice was available from a local support group. Patients who may be in need of extra support were identified by the practice. Quality and Outcomes Framework system (QOF) figures indicated the practice was performing well in relation to reviewing patients with mental health illness.

For example, the percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (01/04/2013 to 31/03/2014) was 88% compared with a national figure of 84%.

The practice's uptake for the cervical screening programme was 81%, which was comparable with the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/National averages. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 90% to 96% and five year olds from 90% to 96%. Flu vaccination rates for the over 65s were 79%, and at risk groups 59%, this compared to national figures of 73% and 52% respectively. These were above the national averages.

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

Coordinating patient care

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available in the reception and waiting area.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings, including palliative care, took place on a regular basis and that care plans were routinely reviewed and updated. The care plans we viewed were detailed and person centred, making them an effective tool in maintaining care at the highest level.

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 554 points gained out of a possible 559. This practice was not an outlier for any QOF clinical targets. Data from 2014 showed

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (01/04/2013 to 31/03/2014) was 95% as opposed to the national average of 88%.
 - The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
 - The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (01/04/2013 to 31/03/2014) was above the area average, being 88% as opposed to 84%.

Clinical audits were carried out and all relevant staff were involved to improve care and treatment and people's outcomes. There had been regular clinical audits completed, we looked at several of these. We saw that audits were detailed and effective in identifying learning. Some of the audits we looked had resulted in the learning being shared with the clinical commissioning group (CCG) and then having been adopted by other providers as best practice. The practice participated in applicable local audits, national benchmarking, accreditation and research. Findings were used by the practice to improve services. For

example, recent action taken as a result included a reduction in the prescribing of anti-biotics. Another resulted in a reduction of inappropriate referrals to secondary care.

The practice had a busy research department which was led by one of the partner GPs and employed research and administration staff, partly funded by local enterprise. We saw evidence that the work done in the department had led to a number of successful trials of new and innovative treatments, some of these had been adopted nationally. The Lead GP told us that there were many benefits to running the research, including keeping research and skills in the UK, gaining expertise in new products and patients involved giving very positive feedback.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as fire safety, health and safety and confidentiality.
- 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 these learning needs and to cover the scope of their work. This included ongoing support during sessions, appraisals, coaching and mentoring, and facilitation and support for the revalidation of doctors. We did note that formal one-to-one meetings were not routinely held and nurses were not receiving clinical supervision. The advanced nurse practitioner told us that this was being addressed and plans were in place to involve other practices in clinical supervision for nurses. All staff had had an appraisal within the last 12 months.

Staff received training that included: safeguarding, fire procedures, basic life support and confidentiality awareness. Staff had access to and made use of e-learning training modules and in- house training.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations 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.

All but one of the 17 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Patients did express concern regarding the difficulty in accessing appointments. We also spoke with four members of the PPG on the day of our inspection. They also told us they were very happy with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Notices in the patient waiting room told patients how to access a number of support groups and organisations. 68% patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

The practice's computer system alerted GPs if a patient was also a carer. There was a carer's register the practice checked that carers were being supported, for example, by offering health checks. Written information was available for carers to ensure they understood the various avenues of support available to them.

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

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was comparable to other practices for its satisfaction scores on consultations with doctors and nurses. For example:

- 84% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 80% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 92% say the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 92% and national average of 91%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 on the comment cards we received was also positive and aligned with these views.

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

- 81% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 66% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We

Are services caring?

saw notices in the reception areas informing patients this service was available. We noted that having listened to patients views the practice had installed a hearing loop to assist patients who required that facility.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was working with the local CCG to improve outcomes for patients in the area. For example they had recognised the need to improve access for patients to appointments and speed of answering the telephone. Recently there had been promotion of online appointment booking, the fitting of a new electronic patient arrival facility, a location move of staff answering the telephones, additional reception staff at peak times, increased surgery times and data analysis to better understand demand. This had led to an increase of the number of calls answered, with 7,939 answered in October 2015 compared with 6,903 in June 2015.

There was an active PPG with 12 members which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. The PPG also produced a quarterly newsletter which was made available to patients.

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

- The practice offered Saturday morning appointments, early surgeries on Wednesday from 7.00am and late appointments on Thursday evenings. These were aimed at working patients who could not attend during normal opening hours or other patients who found office hours more difficult for attending appointments.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients and other patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 8.30 to 6.00pm each day. Extended hours surgeries were offered from 7.00am on Wednesdays, up to 8.00pm on Thursdays and every Saturday morning between 9.00am and midday. In

addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available as well as emergency telephone consultations midweek between 6.00pm and 6.30pm.

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

- 65% of patients were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 19% patients said they could get through easily to the surgery by phone compared to the CCG average of 62% and national average of 73%.
- 46% patients described their experience of making an appointment as good compared to the CCG average of 68% and national average of 73%.
- 59% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 59% and national average of 65%.

Listening and learning from concerns and complaints

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

We saw that there was no information available in the reception or waiting area to help patients understand the complaints system. When we asked about this, we were told that there were complaint forms on the computer but none had been printed off. Some complaint forms were soon printed off and made available for patients. The Practice Manager told us that better information about how to make a complaint would be made available in the waiting area. Patients we spoke with were confident they would be able to make a complaint should they need to. We established from staff at the practice that they often dealt with minor complaints without recording them; we were told that in future all complaints would be documented.

We looked at two complaints received in the last 12 months and found they were dealt with in an appropriate manner, we saw from minutes of meetings that complaints were discussed by staff at meetings.

Are services responsive to people's needs? (for example, to feedback?)

The staff suggestion scheme, which had recently been introduced, resulted in an office move for some staff so that telephone calls from patients could be better dealt with in a room more conducive to effective call handling. We were told that this staff led initiative had resulted in a higher

level of service to the patients. The management at the practice planned to survey the satisfaction of patients calling the practice and were confident that it would have increased.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had an aims and objectives summary, which was displayed in the waiting area and some staff did now know what the aims and objectives of the practice were. We saw from minutes of meetings that the aims and objectives of the practice had been discussed with some staff at a meeting in May 2014. The lead GP told us that further embedding of the practice strategic aims would be included in future staff development plans.

The management at the practice had clear plans to maintain effective succession planning. For example the current Practice Manager was planning to retire in 2016 and the handover of responsibilities was already taking place. The lead GP told us that recruiting new GPs had proved difficult and alternative strategies for providing clinical support had been employed. An advanced nurse practitioner had been employed, together with a patient experience manager, who had together added significant value to the delivery of care.

Governance arrangements

The practice had an overarching governance policy. This outlined the structures and procedures in place and incorporated nine key areas: patient involvement, clinical audit, evidence based medical treatment, staff and staff management, information and its use, risk control, continuous professional development, patient experience and strategic capacity.

Governance systems in the practice were underpinned by:

- A clear staffing structure and a staff awareness of their own roles and responsibilities.
- Practice specific policies that were implemented and that all staff could access.

- A system of reporting incidents without fear of recrimination and whereby learning from outcomes of analysis of incidents actively took place.
- A system of continuous effective audit cycles which demonstrated an improvement on patients' welfare.
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- A system of sharing best practice with other providers in the area.
- Proactively gaining patients' feedback and engaging patients in the delivery of the service. Acting on any concerns and suggestions raised by both patients and staff.
- The GPs were all supported to address their professional development needs for revalidation and all staff in appraisal schemes and continuing professional development. Two of the partner GPs were also qualified to assess other GP's performance and have input into their professional development.

Innovation

The practice team was forward thinking and engaged in local and national initiative, for example the Prime Minister's challenge fund. The practice had also recognised the changing demographics of its catchment area. For example the population of the area was expanding by around 2.5% per annum and the practice planned to meet their increased patient numbers by increasing staff accordingly.

The practice had a research unit led by one of the GP partners. The department employed researchers and staff and worked in conjunction with partner organisations to innovate and test new medical advances. The research unit had been involved in the testing of a number of new medicines and had trialled them with some of the patients at the practice who agreed to be involved. Some of those trial treatments had been introduced nationally and were seen to be advances in patient care and provided improved patient outcomes.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17.</p> <p>The provider is failing to meet this regulation as it has not acted and made improvements following repeated feedback from patients about the lack of access to appointments and difficulty in getting through on the telephone. This can be seen by the results of the July 2015 GP survey. “19% find it easy to get through to this practice by phone compared with a CCG average of 62% and a national average of 73% and 74% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 84% and a national average of 85%.” It is further evident from the direct feedback by patients to the practice over the preceding months and to the CQC on the day of the inspection.</p> <p>Regulation 17 states:</p> <ol style="list-style-type: none">1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—<ol style="list-style-type: none">A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;C. maintain securely an accurate, complete and contemporaneous record in respect of each

Requirement notices

- service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;
 - D. maintain securely such other records as are necessary to be kept in relation to—
 - a. persons employed in the carrying on of the regulated activity, and
 - b. the management of the regulated activity;
 - E. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;
 - F. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).
3. The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—
- A. a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and
 - B. any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.