

Dr Fisher & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
The six population groups and what we found	6
What people who use the service say	10

Detailed findings from this inspection

Our inspection team	11
Background to Dr Fisher & Partners	11
Why we carried out this inspection	11
How we carried out this inspection	11
Detailed findings	13

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Fisher & Partners on 7 July 2016. Overall the practice is rated as good.

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

- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.

- Risks to patients were assessed and well managed.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had a strong ethos for training. Clinical staff were able to access a number of different training elements. This included a monthly dedicated practice educational meeting, protected learning time, talks from external professionals and daily shared learning with other staff members.
- The provider was aware of and complied with the requirements of the duty of candour.
- The practice had reviewed patient access and was able to offer evening appointments every week day until 8pm. This service was jointly run with another local practice.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- The practice was clean and tidy and there were arrangements in place to ensure appropriate hygiene standards were maintained.
- Risks to patients were assessed and managed. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The practice had policies and procedures in place to help with continued running of the service in the event of an emergency.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were average when compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had a strong ethos for training. Clinical staff were able to access a number of different training elements. This included a monthly dedicated practice educational meeting, protected learning time, talks from external professionals and daily shared learning with other staff members.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice was open from 7.30am to 6.30pm every weekday and had reviewed patient access to the service. Evening appointments were available from 6.30pm to 8pm every day. This service was jointly offered with another practice. Every other Saturday morning appointments were available from 8am to 11.30am.
- The practice website had information in relation to different long terms condition including information for diabetes during Ramadan or fasting.

Good



Are services well-led?

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

Good



Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had patients registered who resided in several local care homes.
- Older patients with complex care needs and those at risk of hospital admission all had personalised care plans that were appropriately shared with local organisations to facilitate the continuity of care.
- The practice was working to the Gold Standards Framework for those patients with end of life care needs. (The Gold Standards Framework is a framework to enable a standard of care for all people nearing the end of their lives. The aim of the Gold Standards Framework is to develop a locally-based system to improve and optimise the organisation and quality of care for patients and their carers in the last year of life).
- The practice telephoned patients upon their discharge from hospital to offer support, and to enquire whether a visit or other assistance was required.
- The practice worked with the integrated care team to improve communication between different services, for patients who were vulnerable or had complex needs

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.
- Performance for diabetes related indicators was either on par or slightly lower than the clinical commissioning group (CCG) and national average. For example, 81% of patients on the diabetes register, had a record of a foot examination taking place within the last 12 months. The local CCG average was 84% and the national average was 88%.
- For patients with more complex diabetic needs the practice could refer to the local community diabetes nurse specialist.

Good



Summary of findings

- 90% of patients with **chronic obstructive pulmonary disease** (COPD) had a review undertaken including an assessment of breathlessness, which was the same as the national average of 90%
- Patients were supported to self manage their long term condition by using agreed plans of care and were encouraged to attend self-help groups.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice website had information in relation to different long terms condition including information for diabetes during Ramadan or fasting.

Families, children and young people

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

- The practice GPs had a personalised list based system keeping families registered together with one GP.
- 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.
- Practice staff had received safeguarding training relevant to their role and knew how to respond if they suspected abuse. Safeguarding policies and procedures were readily available to staff.
- The practice ensured that children needing emergency appointments would be seen on the same day.
- Immunisation rates were average 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.
- The practice offered Saturday flu clinic appointments for children to fit in around working parent's commitments.

Good



Summary of findings

- The number of women aged between 25 and 64 who attended cervical screening in 2014/2015 was 78% compared to the clinical commissioning group (CCG) and national average of 82%
- We saw positive examples of joint working with midwives and health visitors.
- The practice offered family planning and routine contraception services including implant/coil insertion.
- The practice had a variety of self-help leaflets and information. This included information targeted to young patients – a leaflet providing information about how to access services at the practice and the local area.

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 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 was open from 7.30am to 6.30pm every weekday. The practice had extended opening and offered evening appointments every week day until 8pm. This service was jointly run with another local practice. Every other Saturday morning appointments were available.
- The practice offered advice by telephone each day for those patients who had difficulty in attending the practice and there were daily evening emergency appointments available.
- Patients were able to access their repeat prescription online and were able to have this collected by a pharmacy of their choice, which could be closer to their place of work if required.

Good



People whose circumstances may make them vulnerable

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

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

Good



Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice could accommodate those patients with limited mobility or who used wheelchairs.
- Carers and those patients, who had carers, were flagged on the practice computer system and were signposted to the local carers support team.
- The practice worked with the integrated care team in order to improve support and communication between different services for patients.

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).

- 81% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average of 84%
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. 272 survey forms were distributed and 122 were returned. This represented 1% of the practice's patient list.

- 88% of patients who responded found it easy to get through to this practice by phone compared to the national average of 73% and the clinical commissioning group (CCG) average of 82%.
- 83% of patients who responded were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76% and the CCG average of 84%.
- 97% of patients who responded described the overall experience of this GP practice as good compared to the national average of 85% and the CCG average of 92%.
- 86% of patients who responded said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79% and the CCG average of 90%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 26 comment cards which were all positive about the standard of care received with the exception of one. Patient's described the GPs and nurses as caring, professional and told us that they were listened to. Comments written by patients included that they felt staff were friendly, approachable and attentive.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Patients told us they were given advice about their care and treatment which they understood and which met their needs. They described the GPs and nurses as kind and told us they always had enough time to discuss their medical concerns.

A Friends and Family Test suggestion box was available within the reception area. Data from January 2016 to June 2016 showed that 110 patients had responded, with 94% of patients recommending the practice.

Dr Fisher & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Dr Fisher & Partners

Dr Fisher & Partners offers general medical services to the population of Camberley, Surrey and the surrounding area. There are approximately 9,700 registered patients.

Dr Fisher & Partners is a large purpose built building owned and maintained by NHS Property Services. The ground floor has full disabled entrance access with a large seated reception area. The GP consulting rooms and treatment rooms are all located on the ground floor. The first floor has access by stairs or lift, where staff offices and facilities are located. There is a toilet for people with disabilities on the ground floor, which also has baby changing facilities. The building is shared with other health care providers.

Dr Fisher & Partners is run by five partner GPs (one male and four female). The practice is also supported by two salaried GPs, and a registrar. There are also three nurses, a trainee healthcare assistant and a team of receptionists and administrative staff, a patient services manager and a practice manager.

Dr Fisher & Partners is a training practice for GP trainees and FY2 doctors. (FY2 Doctors are newly qualified doctors who are placed with a practice for four months and will have their own surgery where they see patients).

The practice runs a number of services for its patients including asthma reviews, child immunisation, diabetes reviews, new patient checks and holiday vaccines and advice.

Services are provided from:-

Camberley Health Centre, 159 Frimley Road, Camberley, Surrey GU15 2QA

Opening Hours are:-

Monday to Friday 7.30am to 6.30pm

Saturday 8am to 11.30am

The practice had extended opening and offered evening appointments every week day until 8pm. This service is jointly run with another local practice.

During the times when the practice is closed, the practice has arrangements for patients to access care from an Out of Hours provider, this can be accessed for patients via the 111 service.

The practice population has a higher number of patients aged between 45 to 59 years of age than the national and local clinical commissioning group (CCG) average. When compared to the national and local clinical commissioning group (CCG) averages, the practice population shows a slightly lower number of patients aged from birth to 9 years of age and 30 to 39 years of age. The percentage of registered patients suffering deprivation (affecting both adults and children) is lower than the average for England. Less than 10% of patients do not have English as their first language.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 7 July 2016. During our visit we:

- Spoke with a range of staff including GPs, nurses, a healthcare assistant, administration and reception staff and the practice manager.
- We also spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.
- There was a clear learning cycle documented for any incidents or significant events for the practice.
- The practice held a rolling meeting programme which covered multiple topics. For example, monthly partner meetings, education meetings, clinical team meetings and priority patient meetings. Topics such as audits, complaints and comments, significant events and updates were discussed at these meetings.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a significant event had been raised due to a patient being booked in under the correct date of birth but the wrong name. Staff were reminded to check both patients name and date of birth and we saw that this reminder had been cascaded to all staff members.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements

reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were clear lead members of staff for safeguarding. The GPs attended safeguarding meetings and discussed concerns with health visitors. Reports were provided where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three and nurse to level two.

- A notice in the waiting room and in the treatment rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Clinical staff were asked to act as chaperones.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice nurse had recently taken on the role as infection control lead. We saw they were booked to undertake the required training and there was a plan to cascade training to other staff members once completed. An infection control policy and supporting procedures were available for staff to refer to. This enabled staff to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy

Are services safe?

teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- The practice had procedures in place to manage controlled drugs safely including their destruction (controlled drugs are medicines that require extra checks and special storage because of their potential misuse). At the time of the inspection the practice did not have any controlled drugs on the premises.
- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises

such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. We noted that a poster with photographs of the emergency medicines and their location was on display in the reception staff area. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, after reviewing the new guidance for diabetes the practice had reviewed and changed the diabetes template to ensure GPs captured all information required.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The GPs shared a morning break session with each other. This was used to discuss patients and to share knowledge and expertise.
- The practice used computerised tools to identify patients with complex needs and those that had multidisciplinary care plans documented in their case notes. This ensured that staff authorised to review patients' notes were aware of the most up to date information available
- Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of the patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2014/15) show that the practice achieved 89.3% of the total number of points available. The practice had a 4.2% exception rate. This was low when compared with the national average and local clinical commissioning group average of 9% (Exception reporting is

the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators were either comparable or slightly lower than the national average. For example, 80% of patients with diabetes, whose last measured total cholesterol was in a range of a healthy adult (within the last 12 months), which was comparable to the national average of 80% and the clinical commissioning group (CCG) average of 81%. The practice had worked to improve this figure and the QOF score for 2015/2016 was 82%.
- 81% percent of patients on the diabetes register, had a record of a foot examination in the last 12 months which was slightly lower than the national average of 88% and the CCG average of 84%. The practice had recognised they were slightly below the CCG and national average score and the QOF score for 2015/2016 was improved at 91%.
- 77% of patients with hypertension had regular blood pressure tests performed, which was lower than the CCG average of 80% and the national average of 83%.
- Performance for mental health related indicators were lower than the national average. For example, 69% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of agreed care plan documented in the record, compared to the national average of 88% and CCG average of 90%. However, we noted that the exception rate was low when compared to the CCG and national averages. The practice had recorded that 54 patients had been excluded from their figures which was an exception rate of 3.7%. Whereas the CCG rate was at 11% and the nation average rate was 13%. This meant that the CCG and national rates were excluding more patients.
- 78% of patients with asthma had an asthma review in the last 12 months which was higher than the national average of 75% and the clinical commissioning group (CCG) average of 73%.

Are services effective?

(for example, treatment is effective)

- Performance for chronic kidney disease related indicators were the same as the CCG and national average of 96%

We spoke with the practice in relation to some of their low scores specifically the diabetic QOF scores. The practice had investigated this and was able to explain that their exception reporting was low due to GPs wishing to continue to try to engage with patients to attend reviews. The practice has worked hard to improve the 2014/15 QOF figures and the 2015/16 figures were noticeably higher. The practice had also been without a practice nurse and felt this had may have affected their figures although GPs had taken over some of this role. We saw that a new practice nurse had been employed and that they and two GPs had attended an extensive diabetes course in order to further help patient manage this condition.

There was evidence of quality improvement including clinical audit.

- Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients' outcomes. We reviewed six clinical audits that had been carried out within the last 18 months. The audits indicated where improvements had been made and monitored for their effectiveness. We saw that the practice also completed audits for medicine management and infection control.
- The practice participated in local audits, national benchmarking, accreditation and peer review. The staff we spoke with discussed how, as a group, they had reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.
- Findings were used by the practice to improve services. For example, the practice had completed an audit to determine if asthma patients who were prescribed 12 Ventolin inhalers or more were being managed in line with Health and Care Excellence (NICE) guidelines. The practice had recognised that four out of 16 patients who had required a further review had not attended. The results were discussed at an education meeting where it was recognised that these patients had all been reminded to attend a review via a written format. It was discussed if telephone reviews would benefit patients.

- Information about patients' outcomes was used to make improvements. For example, the GPs meet on a daily bases to discuss patients. This ensured shared learning for the appropriate on-going support for patients.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines, taking samples for cervical screening and taking blood samples had received specific training which included an assessment of competence.
- Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- The practice had a strong ethos for training. Clinical staff were able to access a number of different training elements. This included a monthly dedicated practice educational meeting, protected learning time, talks from external professionals and daily shared learning with other staff members.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and confidentiality. Staff had access to and made use of e-learning training modules and in-house training. The practice made use of a training matrix which highlighted gaps in staff training. We saw that any gaps had been recognised and dates for training to be completed by had been planned with staff. For example, two out of 10 administration

Are services effective?

(for example, treatment is effective)

staff had not completed their Mental Capacity Act (2005) & Consent training. The staff members had been informed this was overdue and had been given the date of 22 July 2016 to have it completed by. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the healthcare assistant we spoke with told us they had first been employed as a receptionist and had taken on extra training in order to gain further skills to become a healthcare assistant.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results. The practice had a system which involved staff carrying out checks to make sure that any 'two-week wait' cancer referrals they had sent had been received, and acted upon, by the relevant hospital department.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice had made use of the gold standards framework for end of life care. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. (The Gold Standards Framework is a framework to enable a standard of care for all people nearing the end of their lives. The aim of the Gold Standards Framework is to develop a locally-based system to improve and optimise the organisation and quality of care for patients and their carers in the last year of life).
- The practice provided an enhanced service to patients attending the practice who may require a more multi-disciplined service of care. Information was shared with relevant health care providers to enhance the care provided. For example, patients who were most likely to be subject to unplanned hospital admissions. Patients were also highlighted on the practice computer system so that their care could be prioritised.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan

ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young patients, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Health information was made available during consultations. GPs and nurses used materials available from online services to support the advice they gave patients. There was a variety of information available for health promotion and prevention in the waiting area and on the practice website
- Midwives were available at the practice.
- The practice offered family planning and routine contraception services including implant/coil insertion.
- The practice's uptake for the cervical screening programme was 78%, which was slightly lower than the local clinical commissioning group (CCG) and national average of 82%. The practice had completed a cancer audit in June 2016 where it had recognised that figures were not as high as previously and actions were in place to send reminders to patients who had not attended for a recent test. There were systems in place to ensure

Are services effective? (for example, treatment is effective)

results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Bowel cancer screening rates in the last 30 months for those patients aged between 60 and 69 years of age were 62% which was comparable with the CCG average of 62% and a national average of 58%.
- The practice had a lower number of children registered at the practice than the CCG and national average. It must be noted that a low numbers of children eligible to

receive a vaccination can give a disproportionate percentage variance. Most childhood immunisation rates for vaccines given were either the same or lower than the CCG average. For example, 79% of children under 24 months had been given the MMR (measles, mumps and rubella) vaccine compared to the clinical commissioning group average of 89%. Whereas 90% of five year old children had received dose one for MMR vaccine which was comparable to the CCG average of 91%. A system was in place for the practice to contact the parent or carer of those patients who did not attend for their immunisations.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The reception desk and waiting area were separate which helped with patient confidentiality and the practice had installed an electronic booking in system in order that patients could check themselves in for an appointment, away from the reception desk.
- There were number locks on the door for the GP and nurses rooms. This prevented unauthorised access to treatment areas.

25 of the 26 patient Care Quality Commission comment cards we received were positive about the service experienced. One comment card we received gave negative concerns of the care received by a family member. The other patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. All of the five patients we spoke with felt the practice staff were friendly and treated them with kindness.

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

- 90% of patients who responded said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 90% of patients who responded said the GP gave them enough time compared to the CCG average of 90% and the national average of 86%.

- 96% of patients who responded said they had confidence and trust in the last GP they saw which was the same as the CCG and national average of 96%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 95% and the national average of 91%.
- 92% of patients who responded said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 89% of patients who responded said the last GP they saw was good at explaining tests and treatments compared to the clinical commissioning group (CCG) average of 90% and the national average of 86%.
- 90% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 81%.
- 91% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

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

- Information leaflets were available in easy read format.

Are services caring?

- Staff told us that there were aware of a number of patients who needed the aid of a sign language interpreter and were able to book this service for patients when needed.
- The practice's electronic booking system was available in five different languages. The practice was aware that they had a number of patients who spoke Nepalese and Polish and these were included in the languages available.
- The practice website also had the functionality to translate the practice information into approximately 90 different languages.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 156 patients as carers (nearly 2% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. 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. We noted that a flag was placed onto family members' computer records informing staff of the bereavement, this ensured that staff could offer a more flexible approach to services provided where needed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice had reviewed patient access and was open from 7.30am to 6.30pm every weekday. Evening appointments were available from 6.30 to 8pm every day and this service was jointly provided with another practice. Every other Saturday morning appointments were available.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The waiting area was able to accommodate all patients including those with limited mobility or who used wheelchairs. There were also toilet facilities available for all patients, including an adapted aided toilet and a baby changing facility.
- The practice remained open throughout the day. Patients were able to ring the practice or drop off prescriptions or samples during their lunchtime period.
- A hearing loop and translation services were available and the practice used sign language services to help those with a hearing impairment and who were British Sign Language users.
- The practice used text messaging to remind patients of appointments.
- Electronic Prescribing was available which enabled patients to order their medicines on line and to collect it from a pharmacy of their choice, which could be closer to their place of work if required.
- The practice telephoned patients on discharge from hospital to offer support, and enquire whether a visit or other assistance was required.

- The practice offered advice by telephone each day for those patients who had difficulty in attending the practice and there were daily evening emergency appointments available.
- The practice website had information in relation to different long terms condition including information for diabetes during Ramadan or fasting.

Access to the service

The practice was open between 7.30am and 6.30pm Monday to Friday. Saturday morning pre-bookable appointments were available from 8am to 10.30am every other week. Evening appointments were available from 6.30 to 8pm every day and this services was jointly provided with another practice. In addition to pre-bookable appointments which could be booked in advance, urgent appointments were also available for patients that needed them.

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

- 90% of patients who responded were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 82% and the national average of 78%.
- 88% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 83% and the national average of 73%.
- 83% of patients who responded said the last time they wanted to see or speak to a GP or nurse from their GP practice they were able to get an appointment compared to the CCG average of 84% and the national average of 76%.

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

The practice had a system in place to assess:

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

Reception staff recorded information centrally for the GPs on the appointment system. GP telephoned the patient or carer to gather further information. This ensured home visits were prioritised according to clinical need. In cases where the urgency of need was so great that it would be

Are services responsive to people's needs?

(for example, to feedback?)

inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

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

- We saw that information was available to help patients understand the complaints system. There were posters on display in the waiting area, a complaints leaflet and information was on the practice website.
- None of the five patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found these were all discussed, reviewed and learning points noted. We saw these were handled and dealt with in a timely way. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was on the practice website and staff knew and understood the values.

The mission statement was:

- To improve the health, well being and lives of those they care for.

The vision was:

- To work in partnership with their patients and staff to provide the best Primary Care services possible working within local and national governance, guidance and regulations.

The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

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

Leadership and culture

On the day of inspection, the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

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

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

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

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

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through surveys sent to the virtual patient participation group (VPPG) and through complaints and comments received.
- The practice had gathered feedback from staff through staff meetings, appraisals and general discussions. Staff

Are services well-led?

Good 

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

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

- A Friends and Family Test suggestion box was available within the patient waiting area which invited patients to provide feedback on the service provided. Results showed that from January 2016 to June 2016, 110 patients had responded with 94% (103) extremely likely or likely to recommend the practice, 3% (three) patients who had no opinion and 3% (four) patients who would not recommend the practice.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward to improve outcomes for patients in the area. For example:-

- The practice had a strong ethos for training. Clinical staff were able to access a number of different training elements. This included a monthly dedicated practice educational meeting, protected learning time, talks from external professionals and daily shared learning with other staff members.
- The practice was a training practice for doctors and was looking to train nurses as part of their degree course in the future.
- The practice had recognised the need to improve services for those patients on blood thinning medication (Warfarin) and was planning to move to finger pricking testing in the future.
- The practice was taking part in a Musculoskeletal (MSK) pilot to help reduce surgical intervention.