# University 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 | Outstanding ☆ |
| Are services safe? | Good ● |
| Are services effective? | Good ● |
| Are services caring? | Good ● |
| Are services responsive to people's needs? | Outstanding ☆ |
| Are services well-led? | Outstanding ☆ |

# Summary of findings

## Contents



## Overall summary

We undertook a comprehensive inspection of the University Medical Centre on 28 January 2015. We have rated the practice overall as outstanding.

Specifically, we found the practice to be outstanding for providing responsive service and for being well led. It was also outstanding for providing services for the people with long-term conditions, for working age people (including those recently retired and students), for people whose circumstances may make them vulnerable and for people experiencing poor mental health (including people with dementia). It was good for providing caring, effective and safe services.

Our key findings were as follows:

- The practice was responsive to the needs of the local population and engaged effectively with other services.
- There was a culture of openness, transparency, continual learning and improvement within the practice.
- The practice was committed to providing high quality patient care and provided good support and training to staff to facilitate this.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place,

# Summary of findings

was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice had a clear vision, a strong learning culture and was committed to continued quality improvement. This culture was embodied by all of the staff. Staff responded to change and were encouraged to bring suggestions for improvement. All staff were united to deliver the practice vision, of providing high quality care to patients.
- The practice promoted work with young people and schools as part of "You're welcome initiative". This included engaging students by offering work experience opportunities at the practice. The practice nurse had written a book on immunisations and used this to educate young children. The practice had engaged with students on a work experience basis, and had asked them to review the services they offered to teenagers and young patients.
- Innovative approaches were evident to enable patients in vulnerable groups to access care services. For example, the practice held weekly diabetes clinics using the 'House of Care' model, in line with best practice. The practice hosted a Diabetic Eye screening clinic specifically for the residential care home patients with diabetes. The practice had arranged for a psychiatrist to hold regular clinics onsite to enable easy access to students, and audits showed this had positive impact on patients.

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned 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 were enough staff to keep patients safe.

**Are services effective?**

Good

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 National Institute for Health and Care Excellence and used it routinely. Patient's 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.

**Are services caring?**

Good

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

**Are services responsive to people's needs?**

Outstanding

The practice is rated as outstanding 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

# Summary of findings

(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 the need for these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, with continuity of care and 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 the practice responded quickly when issues were raised. Learning from complaints was shared with all practice staff.

**Are services well-led?**

**Outstanding** ☆

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had an active patient participation group (PPG).

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice provided good care to older patients. The practice had a very low proportion of elderly patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population. All patients had a named GP. All patients in this population group were offered flu vaccinations, and 85% of these patients had received their flu vaccination. Staff were able to recognise signs of abuse in older people and knew how to escalate or refer these concerns. The premises and services had been adapted to meet the needs of people with mobility problems. We saw that the waiting area and treatment rooms were able to accommodate patients with wheelchairs. Disabled Access toilet facilities were available. The practice held regular multi-disciplinary team meetings to ensure systems were in place to try to reduce the number of hospital admissions.

**People with long term conditions**

Outstanding

The practice is rated as outstanding 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.

The practice provides a weekly diabetes clinic run by two diabetes nurses using the 'House of Care' model, in line with best practice. The practice achieved the Premium Payment from the Clinical Commissioning Group in 2014 for achieving over 70% on each of the nine diabetes care processes. The practice hosted a Diabetic Eye screening clinic specifically for the residential care home patients with diabetes. The practice had information about long term conditions on the practice website and leaflets were also available at the practice. The practice had a robust recall system which ensured patients with one or more long term condition were able to have their bloods checked at the same time as their review appointment, for example diabetes and thyroid.

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**Families, children and young people**

Good

The practice is rated as good for quality of care to families, children and young children. A pregnancy planner was available with information from inception to birth and beyond. GPs carried out a home-visit to provide new baby checks for babies born at home. All new mothers had access to midwives, who held weekly clinics onsite. Childhood immunisations were carried out at the practice. The immunisation rate was monitored and take up was good. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. The practice had set up a social media page and actively promoted this to maximise interaction with young patients about their health and medicines. Staff had completed training in domestic violence and Identification and Referral to Improve Safety (IRIS), to ensure staff were able to take appropriate action. The GPs reviewed and discussed all patients on the safeguarding register every fortnight.

**Working age people (including those recently retired and students)**

Outstanding

The practice is rated as outstanding 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 provided medical services to students of University of Reading. The practice offered a range of clinics to support this patient group. For example, family planning, contraception and gynaecology. The practice offered weekly walk-in sexual health and contraception clinic. 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 provided a range of scheduled appointments between 8am and 6pm Monday to Friday. The practice offered early morning and evening appointments. The practice was also open one Saturday morning each month. Telephone calls to patients who were at work were made at times convenient to them. Smoking cessation clinics were offered to patients. There was health promotion material available in the waiting area and on the website. This included sexual health and family planning advice and information on healthy lifestyle was also available. The practice has a duty team, consisting of a GP and nurse who will see emergencies and minor illnesses on the day.

# Summary of findings

**People whose circumstances may make them vulnerable**

Outstanding 

The practice is rated as outstanding 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. All registers were reviewed and discussed regularly. All homeless patients were placed on the practice cause for concern list, and the practice used their own address if the patient did not have a fixed abode. Patients who lived in hostels, the practice offered weekly telephone consultations. If patients were unable to attend the practice they were sign-posted to a local service for homeless people. This service was nurse lead clinic where patients could also access food, clothes, mental health support and advice.

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.

**People experiencing poor mental health (including people with dementia)**

Outstanding 

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). Special registrations were arranged for new students who had declared a mental health condition on their university application. This included a 20 minutes appointment with GP followed by an appointment with the Mental Health worker. The patient was then offered appointments with the same GP throughout their studies. Through research the practice had identified the need for a psychiatrist onsite, for students and a request was made to the University of Reading. The University now funds a psychiatrist, who runs a clinic once a week during term time .An annual audit of this service was performed last year and it showed that of the 33 students seen by the psychiatrist, 80% of patients were able to continue with their studies.

The GP mental health lead meets with the Head of Student supports services (who also covers Disability and Counselling services) at the University of Reading on a weekly basis to discuss complex patients with information sharing consent form in place. The practice hosts a weekly Eating Disorders clinic to which students could self- refer. The duty doctors saw patients, on the day, with suicidal tendencies

# Summary of findings

or who had been referred by the student counselling service. The practice provided weekly GP follow up appointments to patients who were especially vulnerable and at risk due to their mental health. These patients were routinely offered a monthly review.

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## What people who use the service say

We spoke with 12 patients which also included members of the patient participation group (PPG). A PPG is made up of a group of volunteer patients and practice staff who meet regularly to discuss the services on offer and how improvements can be made. The majority of the feedback from patients was very positive. The patients we spoke to said they were very happy with the service they received. Most people were happy with the appointment system and all knew they could speak to a doctor or a nurse over the phone whenever they needed to. All patients spoken with were happy with the cleanliness of the environment and the facilities available.

We received further feedback from 21 patients via comment cards. The comments cards reviewed were generally very positive. Patients described staff as kind, caring and friendly. Patients commented GPs and nurses explained procedures in great detail and were always available for follow up help and advice.

We reviewed patient feedback from the national GP survey from 2014 which had 73 responses. The results from the national GP survey showed, 95% of patients described their experience of making an appointment as good and 95% of patients said it was easy to get through to this surgery by phone. Ninety two per cent of patients said the last appointment they got was convenient. Overall 91% patients said they would recommend the surgery to someone new to the area. These results were above the CCG average.

## Outstanding practice

- The practice had a clear vision, a strong learning culture and was committed to continued quality improvement. This culture was embodied by all of the staff. Staff responded to change and were encouraged to bring suggestions for improvement. All staff were united to deliver the practice vision, of provided high quality care to patients.
- The practice promoted work with young people and schools as part of "You're welcome initiative". This included engaging students by offering work experience opportunities at the practice. The practice nurse had written a book on immunisations and used this to educate young children. The practice had engaged with students on a work experience basis, and had asked them to review the services they offered to teenagers and young patients.
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# University Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead inspector, and a GP specialist advisor. The team included a practice nurse, a practice manager and expert by experience.

## Background to University Medical Centre

The practice occupies a purpose built health centre, which was constructed in 1962. The premises had been modified extensively over years, to meet patient requirements. The practice provides primary medical services to over 17,000 patients in Reading, Berkshire. The University Medical Centre has a high proportion of young patients, with high number patients who are overseas students. Consultation and treatment rooms are spread on the ground and first floor. The practice has a lift facility for access to the first floor consultation rooms.

Care and treatment is delivered by 10 GPs, which included 9 females GPs and one male GP, practice nurses, health care assistants and phlebotomist. In addition, the practice is supported by district nurses and health visitors. The practice also works closely works with district midwives. Outside normal surgery hours patients were able to access emergency care from an Out of Hours (OOH) provider. Information on how to access medical care outside surgery hours was available on the practice leaflet, website and waiting area.

The practice has a Primary Medical Services (PMS) contract. PMS contracts are negotiated locally with the local office of NHS England.

There were no previous performance issues or concerns about this practice prior to our inspection.

The practice provides services from:

University Medical Centre

9 Northcourt Avenue,

Reading

Berkshire,

RG2 7HE

## 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. 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.

This provider had not been inspected before and that was why we included them.

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.

## How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback.

# Detailed findings

This included information from the clinical commissioning group (CCG), Reading Healthwatch, NHS England and Public Health England. We visited University Medical Centre on 28 January 2015. During the inspection we spoke with GPs, nurses, the practice manager, reception and administrative staff. We obtained patient feedback by speaking with patients, from comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Good

# Are services safe?

## Our findings

### Safe track record

The practice had systems in place to identify risks and improve quality in relation to patient safety. This was achieved through reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. Staff we spoke with talked through examples of safeguarding alerts they had raised within the last year, and these had been dealt with appropriately.

We reviewed safety record and incident reports. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed records of significant events that occurred during 2014. We saw evidence to confirm staff had completed a significant event analysis which included identifying any learning from the incident. Staff told us learning was shared with them and the practice involved them to share ideas on how the practice could improve service offered to patients.

Multi-disciplinary practice meetings took place where attendance included clinicians from other disciplines such as palliative care nurses, community midwives or health visitors. Minutes from the meetings identified sharing information and reflective practice to reduce risk and improve services going forward.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The practice had a chaperone policy in place. This provided staff with information about when a chaperone should be considered, the role of a chaperone, and who should carry out chaperone duties. The nurses and health care assistant (HCA) acted as a chaperone, and they told us they had received appropriate chaperone training. We saw notices in the waiting area and next to examination couches in the surgeries informing patients that they could request a chaperone.

### Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. Four members

of the nursing team were qualified as independent prescribers. They all had received regular supervision and support in their roles as well as updates in the specific clinical areas of expertise for which they prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a lead for infection control. Staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an infection control audit in December 2014, and any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them 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 and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a completed a legionella (a germ found in the environment which can contaminate water systems in buildings) risk assessment.

**Equipment**

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment. For example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer were all calibrated annually.

**Staffing and recruitment**

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Staff had access to panic buttons and keys on the computer in the event of an emergency.

The practice had systems in place to identify risks to patients and their health. For example, the practice had identified patients needed access to a psychiatrist onsite. This was to ensure patients with mental health issues received appropriate support and treatment. Furthermore to reduce the risk of patients developing mental health problems and to prevent their condition from getting worse.

**Arrangements to deal with emergencies and major incidents**

Good

# Are services safe?

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. They included medicines for the treatment of cardiac arrest, anaphylaxis and diabetic emergencies. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, minor operations, family planning and medicine management. GPs also had other specialist areas that they were leads in and provided support to all the practice staff. These included, clinical protocols, staff development and information governance. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

GPs told us referrals were discussed during team meetings and any improvement to practise were discussed and shared with all the GPs and nurses. For example, the practice had identified they had high referrals rates for breast symptoms and cardiology. The GPs had decided to adopt peer-review system for all referrals before they were sent, to discuss and seek advice whether a referral was necessary.

Discrimination was avoided when making care and treatment decisions. 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 patient's age, gender, race and culture as appropriate.

**Management, monitoring and improving outcomes for people**

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing a wide range of completed clinical audit cycles. These included audits for mental health, minor illness, dermatology, colorectal (a type of cancer) and family planning. We saw evidence For example; we reviewed the urinary tract infection (UTI) audit dated June 2014. The aim of this audit was to evaluate the diagnosis of uncomplicated urinary tract infections. We saw evidence that key points had been summarised and learning was shared with staff. Staff discussed the recording methods and the importance following the relevant professional guidance.

The practice routinely collects information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enabled GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The practice was an outlier for Chronic Obstructive Pulmonary Disease (COPD) and coronary heart disease (CHD). The practice had recognised the data was skewed by the high proportion of students they cater to.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

**Effective staffing**

All GPs had undertaken regular annual appraisals and either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council (GMC) GP continue to practice and remain on the performers list with NHS England).The nursing team had been appraised annually. We saw learning needs had

Good

# Are services effective?

## (for example, treatment is effective)

been identified and documented action plans were in place to address these. Staff told us the practice was proactive and supportive in providing training that been identified.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. There were systems in place to disseminate relevant learning through a structure of team meetings. For example, updates in clinical treatments and protocols were shared with the GPs and nurses on a monthly basis.

Staff told us the practice had good staffing levels as staff retention was high. The GPs covered each other internally, where possible. Staffing levels were frequently reviewed by the practice manager, to ensure they had enough staff members with appropriate skills.

**Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held regular multidisciplinary team meeting to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. The practice used the Choose and Book system to make referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example, one GP talked through a case and how they had applied the MCA 2005. They had completed a best interest meeting and had involved the patient, carer, family and other relevant professionals. It was concluded the patient did have capacity, and it was agreed with all parties involved the patients decision to have or not have the necessary treatment would be respected.

The GPs and nursing staff had a sound knowledge of the Gillick competency considerations, when dealing with young patients. Gillick competence is used to decide whether a person (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental consent or knowledge.

**Health promotion and prevention**

Good

# Are services effective?

## (for example, treatment is effective)

It was practice policy to offer new patients who are over 40 years a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Pneumococcal vaccine was given to patients who are over 65 years of age, in line with national guidance for older people. The practice had achieved 98% for flu immunisations for the local care home they provided medical services to.

There was health promotion material available in the waiting area. This included information on dementia service, dealing with loneliness, and support for patients with learning disability, flu immunisations and carer's information.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and practice surveys. The evidence from most of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the latest national patient survey 2014 showed that 90% of patients said that the GP they saw was good at treating them with care and concern. Ninety eight per cent of patients said the nurse they saw was good at treating them with care and concern and 98% of patients said they had trust and confidence in the GP they saw.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 12 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

A confidentiality policy was in place and staff we spoke with were familiar with this. Staff told us they had received training in patient confidentiality and this was supported by the training document made available to us. During the inspection we observed staff members were careful to follow the practice's confidentiality policy when discussing patient's treatments. This ensured that confidential information was kept private. Staff told us all computers were password protected and only the practice staff had access to the systems.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. There was a visible notice in the practice booklet and website stating the practice's zero tolerance for abusive behaviour.

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed that 91% of patients said the last GP they saw was good at listening to them and 86% of patients said the GP they saw was good at involving them in decisions about their care. Ninety eight per cent of patients stated the nurse they saw was good at giving them enough time and 93% patients said was good at listening to them. The number of patients who stated the nurse was good at explaining tests and treatments was above average for the CCG.

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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. The practice website carried a facility to translate information into 80 different languages.

**Patient/carer support to cope emotionally with care and treatment**

The patients we spoke with were happy about the emotional support provided by the practice. Patients told us the practice staff treated them with compassion and empathy. They described how they had received help to access support services to help them manage their treatment and care when it had been needed. The comment cards we received were also consistent with this feedback. For example, these highlighted that staff responded thoughtfully when they needed help and provided support when required.

Good

# Are services caring?

Notices in the patient waiting room and information on the practice website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We saw evidence that patients were referred to counselling services, including bereavement counselling, when this was appropriate. We saw information about bereavement support was available at the surgery and practice website.

Reception staff told us they would use a private room, should patients wish to speak to them in privacy. Staff told us it was also used if patients were particularly emotional when they attended the practice.

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had adopted the 'House of Care' model, in line with best practice. This model promotes and encourages a holistic approach to the care delivered to patients with long term conditions, to achieve the best possible outcomes. For example, all patients with diabetes received their blood results a week prior to their appointment with the nurse. All practice nurses were trained in motivational interviewing and care planning. The practice had an access to a consultant endocrinologist, who ran virtual clinics. The practice nurses discussed patients with complex conditions and sought advice from the consultant. All patients were sign-posted to the local diabetes website and offered educational courses to support them with their condition. This meant the patient benefitted from person-centred and coordinated care.

Children and young people were treated in an age appropriate way, recognised as individuals and provided with good care. For example, the practice nurse had written a book for child immunisations called 'Coming to see the Nurse'. This book explained to young children the importance of immunisations in a colourful, humorous and pictorial format. This book was very popular with young children and many parents had complimented the nurse's unique approach.

The practice was awarded the 'You're Welcome Award' in 2011. This award recognised the practices engagement with teenagers. For example, the practice had engaged with students on a work experience basis, and had asked them to review the services they offered to teenagers and young patients and how the practice 'felt' to them. Their feedback and recommendations were reviewed and necessary changes were made. The students were also able to learn about the work within general practice, through this work experience scheme. The practice actively promoted "You're Welcome" and had continued this initiative.

The practice worked closely with one residential care home, to ensure patients received consistent care from a named GP. The GPs held twice weekly clinics and managed all the prescriptions .This ensured continuity of care. Each patient had a comprehensive care plan in place. The patient, their family members and the care home were involved and contributed to the final care plan. These care plans were stored onto Adastra (the clinical system for local Out-of-hours (OOH) service) to ensure important medical information was easily accessible to the OOH team. The practice has also hosted a multi-disciplinary team meeting with the care manager to discuss patients' needs and ways how the practice could improve the services offered to the residents.

The GPs worked closely with the care home to improve the service provided. For example, the practice had identified concerns residents were not receiving their flu immunisations in a timely manner. The management team reviewed this position and arranged for the practice nurse to go to the care home and give all the residents their flu immunisation. This ensured the risk of contracting flu was minimised.

An audit on cervical smears had identified the uptake for cervical smears was low. Although the practice had improved over years from 62% to now 67%, the practice was aware these figures remained low in comparison to national average. The practice recognised they faced particular challenges in this area due to the patient population they serve and this skewed their statistics. This was because the practice had a generally high turnover of patients and a very high proportion of these patients were students from overseas, who were often difficult to reach. In order to improve the uptake, the practice consistently offered well women clinics on four out of five days of the week and also clinicians carried out smears opportunistically. The practice had also planned to introduce a text reminder service, to further improve the uptake of cervical smears.

Patients benefited from a stable staff team because staff retention was generally high, which enabled good continuity of care and accessibility to appointments with a GP of choice. All patients needing to be seen urgently were offered same-day appointments and there was an effective triage system in place.

A range of clinics and services were offered to patients, which included student health, minor illness, contraception, female health and phlebotomy. The practice ran regular nurse specialist clinics for long-term

conditions. These included asthma, diabetes and hypertension. Longer appointments were available for patients if required, such as those with long term conditions. GPs placed all new patients who were diagnosed with long term condition on practice register and organised recall programmes accordingly.

The practice did not have any patients from the travelling community who were seeking to register with the practice. However, the practice had access to a specific health visitor for travellers, who they would refer any patients to should the need arise.

We spoke with one member of patient participation group (PPG). They gave us examples of improvements that had been made following discussions between the PPG and the practice. For example, the PPG had suggested the practice provide increased training to the phlebotomist to prevent significant delays in blood tests, and this was actioned by the practice.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example, arrangements were in place to ensure visitors from overseas had regular access to a GP. These patients were registered with the practice and were able to make appointment there. The practice had access to online and telephone translation services. Staff told us the patient record system, alerted staff if a patient was deaf and an induction loop system was in place (induction loops assist patients with hearing aids).

The premises and services had been adapted to meet the needs of people with mobility problems. The doorways were wide and there was space for wheelchairs and mobility scooters to turn. The practice had installed extended hand rails on stairs and seats with arms were available in the waiting areas. All couches in the consultation and treatment rooms were height adjustable. The practice had access to a lift which enabled patients with limited mobility easier access to consultation rooms on first floor. The practice had reserved car spaces for patients with disabilities. The practice had ramp access at the front door of the building. Adapted toilet and washroom facilities were available for patients with disabilities.

Staff had received equality and diversity training in the last 12 months.

**Access to the service**

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice offered a range of scheduled appointments to patients every weekday between the hours of 8am and 6pm. The practice opened for extended hours appointments on a Tuesday and Thursday evenings and offered early morning appointments on Thursday and Friday's. The practice also opened on Saturday mornings, where pre-bookable appointments could be made. This benefitted patients who worked full time.

Patients we spoke with were satisfied with the appointments system. Most patients told us it very easy to get an appointment when they needed. On the day of inspection we found there was availability for patient appointments during the day. There had been very little turnover of GPs during the last five years which enabled good continuity of care and accessibility to appointments with a GP of choice.

The GP national survey 2014 showed 97% of patients were able to get an appointment to see or speak to someone the last time they tried and 92% of patients said the appointment they got was convenient. This was above national average. Ninety five per cent of patients described their experience of making an appointment as good and 58% were seen by their preferred GP.

To ensure that the appointment requirements for different individuals / population groups were met, we found examples of reasonable adjustments made. These included: home visits for older people and housebound patients due to physical and / or learning disabilities, frailty and mental health needs. Flexible appointments for postnatal exams, baby checks, contraception and immunisations as well as appointments outside of school hours were offered. Patients were offered longer

appointments when needed. For example double slot appointments were offered when undertaking annual reviews for patients with learning disabilities and mental health needs.

GP and nurses added more consultations to their normal working day if patient demand was high.

**Listening and learning from concerns and complaints**

Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the practice website and leaflet. The complaints procedure provided further information on how to make complaint on someone's behalf and who at the practice would deal with the complaint. The practice had a clear complaints procedure and this was displayed in the waiting area. This allowed patients to make an anonymous complaint as they were able to provide the information discreetly.

The practice kept a record of all written complaints received. The complaints we reviewed had been investigated and responded to, where possible, to the patient's satisfaction. The practice was open about anything they could have done better, and there was a system in place so learning as a result of complaints was disseminated to staff.

Staff told us complaints were openly discussed to ensure all staff were able to learn and contribute to any improvement action that might be required; and this was reflected in some of the records we looked at.

The patients we spoke with told us they would be comfortable making a complaint if required. They said they were confident a complaint would be fairly dealt with and changes to practice would be made if this was appropriate.

# Are services well-led?

Outstanding ☆

(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, responsive care and to promote good outcomes for patients. Staff told us they were all committed to constantly strive for and deliver the best care to patients, by staying abreast of all latest professional guidance and by embracing new initiatives. All staff we spoke with knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these.

We found details of the vision and practice values were part of the practice's strategy and business plan. The aims and objectives included; providing high quality service to patients, in a friendly, professional and supportive manner; development of workforce to reflect change in patient need and contractual requirements, exploring the possibility of establishing the practice as a teaching practice and to develop an occupational health service onsite. The GP partners regularly monitored and reviewed these objectives and aims.

The management team understood the challenges the practice faced in terms of delivering good quality care, and actions needed to address them. These included, GP succession planning for the two retiring GPs and new IT system had been identified and implemented to ensure the practice was able to work effectively. In addition, the practice had recognised a large proportion of their patient population list was students, and ensured they had enough operational staff to complete the high percentage of registrations and deductions each year.

The practice leaflet and website stated that the practice was interested in the views of their patients and carers and these views were fed into the practice so that they could consider how the service could be improved. The staff were dedicated to providing a service with patient's needs at the heart of everything they did.

**Governance arrangements**

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. All the staff we spoke with were aware of each other's responsibilities. The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. All the policies we looked at had been reviewed and were up to date. The systems and feedback from staff showed us that strong governance structures were in place.

The practice had systems in place for completing clinical audit cycles. All GPs carried out completed audits of clinical conditions of the patients they saw. Examples of clinical audits included dermatology, minor illness, mental health and family planning. We saw the results of audits had been shared with the clinical team within regular clinical meetings. Staff told us the management team had instilled a culture of quality improvement and continuous learning within the practice.

A series of regular meetings took place within the practice which enabled staff to keep up to date with practice developments and facilitated communication between the GPs and the staff team. Significant events and complaints were shared with the practice team to ensure they learned from them and received advice on how to avoid similar incidents in the future.

The proactive engagement between the practice leadership and the Patient Participation Group (PPG) promoted patients views being considered when reviewing the practice's performance and quality improvement work. A PPG is made up of practice patients and staff; and aims to ensure that patients are involved in decisions about a range and quality of services provided by the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

**Leadership, openness and transparency**

The practice had a strong clinical and managerial leadership structure in place. This included four GP partners, a lead nurse who managed the nursing team and an experienced practice manager who was also a partner. The management team had adopted the Belbin Team Inventory Theory, to ensure skills and expertise of the management team were balanced. For example, one staff member was the 'Implementer', as they would take suggestions and ideas from patients and colleagues and turn them into positive actions and get things done. Another staff member was a 'Resource Investigator' as they would explore new opportunities and avenues for the

# Are services well-led?

Outstanding ☆

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

practice to expand and develop new services for patients. A third staff member was the 'Team Worker', as they ensured staff morale was maintained through discussion in meetings, supervision and annual appraisals.

The practice had developed a clear leadership structure which included named members of staff in lead roles. For example, a GP partner was the lead for child and adult safeguarding, another GP was lead for medicine management and there was a lead nurse for infection control. All staff we spoke with were clear about their own roles and responsibilities. Staff described a supportive and inclusive environment where individual roles were valued. The GPs in the practice emphasised a strong focus on education, learning and continuous improvement for all staff and for patients to be supported appropriately.

Staff told us they felt very well supported and knew who to go to in the practice with any concerns. The management team fulfilled a pivotal role within the practice, providing a visible, accessible and effective leadership.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

**Practice seeks and acts on feedback from its patients, the public and staff**

The practice had a virtual patient participation group (PPG), with approximately 23 members. The practice made regular contact with these members to involve them in decisions about the running of the practice. These members were encouraged to share ideas with the practice on how they could improve the service offered to patients. We saw evidence the PPG had advertised information on how to join the group on the practice website and in the waiting area.

We spoke with PPG chairperson who told us they felt valued and thought their views were listened to. We were given examples of where the PPG had highlighted areas where PPG feedback was acted on and changes were made. For example, the PPG members had suggested the practice trained the phlebotomist to take blood tests and other tests, to prevent diabetes patients from significant delay. This recommendation was reviewed and acted upon.

The practice also sought feedback from patients via the 'Comments Book' which was kept in the waiting room and reception area. We saw feedback from patients via this book was received since 2010. We saw many examples, were patients had made comments and suggestions and these were acted upon. For example, we saw one patient had commented that air conditioning was required in the reception area. This comment was reviewed by the practice and air conditioning was installed. We noted every comment in this book was received with an acknowledgment and a full response by the practice. We saw evidence these comments, were then shared and discussed with all practice staff during meetings.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt highly valued as part of the practice team. There were opportunities for formal and informal communication for staff, to ensure issues were raised and managed promptly and appropriately. All staff were encouraged to share ideas for best practice and there suggestions had been acted upon. Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns.

**Management lead through learning and improvement**

All staff told us there was a strong focus on education, learning and continuous improvement, within the practice. They told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. We sampled staff files and saw that regular appraisals took place which included a personal development plan.

Staff told us the practice was very supportive of their individual training needs and they were allowed protected time for team development. Staff were enabled to acquire further qualifications that were relevant to the work they performed and patient health needs. For example, the nurses had received training in their specialist areas, such as travel, family planning and respiratory. The health care assistants were supported by practice to complete their NVQ three qualifications relevant to their role.

Systems were in place for recording and monitoring all staff training needs. We reviewed the staff training document

# Are services well-led?

Outstanding ☆

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

that was made available to us and saw that all staff were up to date with attending mandatory courses such as children and adult safeguarding, equality and diversity, infection control and fire safety.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.