Old Catton Medical Practice

Quality Report

55 Lodge Lane
Old Catton
Norwich
Norfolk
NR6 7HQ
Tel: 01603 415519
Website: www.oldcattonsurgery.nhs.uk

Date of inspection visit: 23 September 2015
Date of publication: 29/10/2015

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

Detailed findings from this inspection

Overall summary

We carried out an announced comprehensive inspection at Old Catton Medical Practice on 23 September 2015. Overall the practice is rated as good.

We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

Our key findings were as follows:

- The practice had a good understanding of the needs of the practice population and services were offered to meet these.
- The practice had robust significant event and complaints procedures and reviewed these regularly to ensure appropriate action would be taken.
- Feedback from patients and observations throughout our inspection showed the staff were kind, caring and helpful. The clinical staff at the practice provided effective consultations, care and treatment in line with recommended guidance.
- New staff received appropriate inductions into their role.
- There was visible practice leadership and staff felt supported by the management and were involved in the vision of providing high quality care and treatment to patients.

We saw one area of outstanding practice:

- The practice had a programme of monthly visiting speakers and consultants to drive staff development and learning. Invitations to attend were circulated to other practices locally. Staff received protected learning time, up to one afternoon per week, if required.

However there was one area of practice where the provider needs to make improvements. Importantly the provider should:

Summary of findings

- Improve the arrangements for the security of blank prescription forms in line with NHS guidance.

Professor Steve Field

CBE FRCP FFPH FRCGP Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was safe and is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report significant events or other incidents. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed and there were effective arrangements to identify and respond to potential abuse. Medicines were managed safely and the practice was clean and hygienic. There were enough staff working at the practice and staff were recruited through processes designed to ensure patients were safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Although data did not always show that patients rated the practice higher than others for several aspects of care, patients we spoke with 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 access. Staff treated patients with kindness and respect ensuring their confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Patients said they did not always found it easy to make an

Summary of findings

appointment with a named GP but that 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 that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients. The virtual patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs and 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 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, staff worked with relevant health and care professionals to co-ordinate and deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people on the safeguarding register. Immunisation rates were in line with local averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The 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 and telephone services as well as a full range of health promotion and screening

Summary of findings

that reflects the needs for this age group. The practice offered extended opening hours on four weekday mornings per week. This benefitted people who were unable to attend the practice during working hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. Since April 2015, 11 out of 18 patients with a learning disability had a received a health check and had a care plan in place. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. During 2014/2015 the practice confirmed 38 out of 44 patients with dementia had a care plan in place.

Staff received training on how to care for people with mental health needs and dementia. Staff had a clear understanding of the 2005 Mental Capacity Act and their role in implementing the Act. The practice signposted and supported patients experiencing poor mental health 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 (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 123 responses which represented a response rate of 47%. The results included:

- 76% find the receptionists at this surgery helpful compared with a CCG and national average of 87%.
- 39% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 61% and a national average of 60%.
- 83% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.
- 85% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 47% feel they don't normally have to wait too long to be seen compared with a CCG and national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received seven comment cards which were all very positive about the standard of care received. There were positive comments about the skills of the staff, the treatment provided by the GPs and nurses and the way staff listened to their needs. There were two positive comments around appointments being available and on time and there were multiple comments around the friendliness of staff and that they listened and were understanding of patients' concerns.

These findings were also reflected during our conversations with four patients during our inspection. The feedback from patients was overall positive. Patients told us about the effectiveness of the triage system and that where necessary they could get an appointment when it was convenient for them with a GP, although not always with the one of their choice. Patients told us they felt staff made time for them and had good communication skills. Patients said they recognised that the practice could be busy and at times had to wait longer than they wanted for their appointment. Patients commented about the GPs and some patients expressed their preference to see their GP of choice. Several comments were made about staff being good with children and that they were generally very friendly. The patients we spoke with told us they felt their treatment was professional and effective and they were very happy with the service provided.

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for the security of blank prescription forms in line with NHS guidance.

Outstanding practice

- Staff received protected learning time one afternoon per week and the practice had a programme of monthly visiting speakers and consultants to drive staff development and learning. Invitations to attend were circulated to other practices locally.

Old Catton Medical Practice

Detailed findings

Our inspection team

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 Old Catton Medical Practice

Old Catton Medical Practice provides general medical services to approximately 7600 patients living in Old Catton, Norwich and the surrounding area. The premises are purpose built and all treatment and consultation rooms are situated at ground level. Parking is available and includes spaces for disabled patients with level access. Entrance doors were not automatic, however we saw an external doorbell was available for patients to call for assistance should they need support accessing the building.

The practice has a team of three GPs meeting patients' needs. These GPs are partners, with one as lead partner, meaning they hold managerial and financial responsibility for the practice. There is one nurse practitioner, two practice nurses, two health care assistants and a receptionist/phlebotomist who run a variety of appointments for long term conditions, minor illness and family health.

There is a practice manager, a patient services manager, a patient services assistant and a reception team manager. This management team is supported by a team of eight non-clinical administrative, secretarial and reception staff, who share a range of roles. The practice also hosts other services, for example community midwives run sessions twice weekly at the practice.

The practice provides a range of clinics and services, most of which are detailed in this report, and operates generally between the hours of 0800 and 1800, Monday to Friday. Appointments were from 0800 to 1230 and 1330 to 1800 every weekday. With early morning appointments from 0730 on every weekday except Tuesday. Pre-bookable appointments could be booked up to four weeks in advance and urgent appointments were available on the day for people that needed them. Urgent appointments underwent a telephone triage process to ascertain the most appropriate course of action for the patient.

Outside of these hours, medical care is provided by Integrated Care 24 Limited (IC24). Primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

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

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

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

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

The inspection team:

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 23 September 2015.
- Spoke with staff and patients.
- Spoke with visiting health professionals.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures. Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. The practice had a policy and a significant event recording form which was accessible to all staff. Records and discussions with GPs identified that there was consistency in how significant events were recorded, analysed, reflected on and actions taken to improve the quality and safety of the service provided. For example one significant event that occurred in 2015 relating to information sent to a deceased patient had been documented clearly and there was evidence it had been discussed within the practice. Actions taken included a letter of apology and a review of the administration process.

Significant events were reviewed annually and were shared with the practice staff to support improvement of the service provided. The practice had also undertaken quarterly reviews of significant events.

Patients affected by incidents received a timely and sincere apology and were told about any actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available. All relevant complaints received by the practice were automatically treated as an incident.

Safety was monitored using information from a range of sources, including National Patient Safety Alerts (NPSA) and the National Institute for Health and Care Excellence guidance (NICE - the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment). Alerts were disseminated to relevant staff electronically and a record was kept of the dissemination, this record was up to date at the time of our inspection. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The practice's computer system highlighted children and adults with safeguarding concerns.
- A notice was displayed in the waiting and treatment rooms, advising patients that chaperones were available, if required. All the practice staff were trained for the role and had received a disclosure and barring check (DBS). (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). Male and female staff were available to provide chaperoning for patients when required.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the practice. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical and clinical equipment was checked to ensure it was safe to use; the practice had implemented a comprehensive scheme to ensure that this was subject to a rolling programme of checks. The practice manager explained thorough understanding of the legislation and informed us that re-checks were planned to take place in 2015.
- The practice had a variety of other risk assessments in place to monitor safety of the premises such as risk assessments for the control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. There was a practice nurse infection prevention and control clinical lead. We saw they liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Infection control audits were regularly undertaken and we saw evidence that action was taken to address any improvements identified. For example, further training needs around infection prevention and control were highlighted and addressed for some members of staff.

Good

Are services safe?

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were not always securely stored and nor was there a system in place to monitor their use. When we raised this with the practice on the day of our inspection, staff acted immediately; we were presented with a draft policy, to ensure tracking of prescription pads took place, on the day. The prescription pads were also immediately stored safely.
- Recruitment checks were carried out and the four staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).
- Hepatitis B immunisation was provided to all staff and records were present in staff files providing evidence this was in place.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and sickness. The rota for the day of the inspection evidenced that staff rostered were on duty as expected. We were informed the practice did not make us of locum GPs and the three GP partners took responsibility for all GP appointments. We were informed that during a GP's time off the other two GPs would cover their role and responsibilities. This left little contingency in the case of a GP becoming unavailable long term. A nurse practitioner and the nurses also took account of a variety of patient demands; there was clear guidance available as to what the nurses, nurse practitioner and GPs would deal with.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Emergency buttons were present in the consulting and treatment rooms, electronically via the computer system and physical buttons that raised an alarm. All staff received annual basic life support training and there were emergency medicines available in the nurses' office. The practice had a defibrillator available and oxygen with adult and children's masks. Emergency medicines were accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan highlighted significant risk and what actions staff should take over different time intervals. The plan included emergency contact numbers for staff and a copy was held off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF - is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice held monthly QOF meetings and had designated staff members in various roles related to QOF, for example one of the GPs acted as QOF lead and clinicians had dedicated administration staff to complete QOF indicators. In 2013/2014 the practice achieved 97.8% of the total number of points available, with 5.2% exception reporting. The practice informed us that their performance had improved in 2014/15. However this data has not yet been validated and will not be made publicly available until 25 October 2015. Data from 2013/2014 showed:

- Performance for diabetes related indicators was better compared to the CCG and national average. With the practice achieving 93.6%, this was 7.6 percentage points above the CCG average and 3.5 percentage points below the national average.
- Performance for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, chronic kidney disease, dementia, depression, epilepsy, heart failure, hypothyroidism, learning disabilities, osteoporosis, palliative care, rheumatoid arthritis and secondary prevention of coronary heart disease were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator.
- Performance for hypertension related indicators was 90.4% which was 8.9 percentage points above CCG average and 2 percentage points above national average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. All GPs and nursing staff were involved in clinical audits. Examples included audits of diabetes patients around GLP-1 agonist (incretin mimetic drugs) prescribing, osteoporosis fragility fractures and hospital admissions. As an example, the osteoporosis fragility fractures audit done in February 2015 was a second cycle audit following the previous year's finding and concluded that some patient medication dosages needed to be changed. A re-audit was planned for August but evidence of this was not yet available at the time of our inspection. Other audits were carried out as part of the GPs' revalidation process.

The practice held a general medical services contract and provided all, except two, of the CCG led enhanced services such as increasing the uptake of screening for cancers and immunisation rates. The two enhanced services that the practice did not participate in were smoking cessation (as the practice had no in-house trained clinician and had good existing arrangements with an external provider that visited the practice) and the enhanced service to support drug users (as the practice had no in-house trained clinician and had recognised low demand in their patient population). Nevertheless, the practice did have referral pathways to external services for drug user support.

Effective staffing

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

- The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. During the inspection we spoke to a member of staff who had joined the practice recently who confirmed induction took place and was staged and delivered effectively.

Good

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, appraisals, staff meetings, clinical supervision and facilitation and support for the revalidation of doctors. All staff files we checked contained evidence that staff had received an appraisal within the last 12 months and each member of staff had future training needs and plans identified from their appraisal. Staff we spoke to confirmed they received appraisals and felt supported in their development.
- Staff received training considered mandatory by the practice that included: safeguarding, fire procedures, basic life support and equality and diversity awareness. Staff had access to and made use of e-learning training modules and in-house training. Staff received additional training suited to their role, for example, three receptionists had received training in dealing with conflict and a child protection update; the management team had received training on domestic violence and abuse; nurses had received training in female genital mutilation. Many other topics were covered in the training programme.
- Staff received protected learning time, up to one afternoon per week, if required.
- The practice had a programme of monthly visiting speakers and consultants to drive staff development and learning. Invites to attend were circulated to other practices locally.

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 the intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example information on vulnerable patients was shared with out of hours services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. This included when people moved between services, including when they were referred, or after they were discharged from hospital. Individual clinical cases were analysed at informal meetings between clinicians. The practice, in conjunction with community nurses, held regular Gold Standard Framework (GSF) meetings for patients who were receiving palliative care. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care, planning and co-ordination of care, support for family and carers and care plans were routinely reviewed and updated.

Clinical staff we spoke with told us about daily opportunities where issues and concerns could be addressed with colleagues. We saw that staff were open about asking for and providing colleagues with advice and support.

Staff we spoke with told us the clinicians and management team were all very approachable and supportive and they were confident they could raise concerns regarding patients with them. We saw that this also took place during clinical meetings and the minutes we reviewed confirmed that this happened.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Staff were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We saw that where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who might be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, those requiring advice on their diet, smoking and alcohol cessation, carers and

Good

Are services effective?

(for example, treatment is effective)

patients suffering bereavement. Patients were then signposted to the relevant service. The practice provided a designated room for the use of other healthcare services and support services; these included a counselling service, physiotherapy, a health trainer and a midwifery service. These were available on the premises in addition to smoking cessation advice from a local support group. Patients who might be in need of extra support were identified and referred by the practice and in some cases patients could refer themselves.

The practice had a comprehensive screening programme. The practice's 2013-14 uptake for the cervical screening programme was 83.9% which was above the national average of 81.9%.There was a policy to offer letter and telephone reminders for patients who did not attend for their cervical screening test.

Childhood immunisation rates for the vaccinations given were comparable to the CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92.8% to 100% and five year olds from 87.1% to 93.1%. Flu vaccination rates for the over 65s were at 69.9% compared to the national figure of 73.2% and at risk groups 45.7% compared to the national figure of 52.3%.

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

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about services to support them in doing this, such as smoking cessation and alcohol intake advice. Information for patients who might be suffering domestic abuse was available this included contact information and access to support services. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

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. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice's switchboard was located near the reception desk, but staff were aware of the need for confidentiality and always attempted to keep information private. Patients commented that confidentiality could be an issue at the front desk when queuing. The practice acknowledged this and informed us a private room to discuss matters would always be available if requested.

All of the seven patient CQC comment cards we received were very positive about the service experienced. There were two comments around appointments being available and on time and there were multiple comments around the friendliness of staff and that they listened and were understanding of patients' concerns. Patients said they felt the practice offered a very good service and staff were professional, helpful, caring and treated them with dignity and respect. We requested to speak with members of the patient participation group (PPG - this is a group of patients registered with the practice who have an interest in the service provided by the practice) but as the group was new, in development and virtual we were informed no one was available on the day. We did speak to four patients on the day. They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the July 2015 national GP patient survey showed patients were relatively happy with how they were treated and that this was with compassion, dignity and respect. The practice performed below average for its satisfaction scores on consultations with doctors and nurses. For example:

- 74% said the GP was good at listening to them compared to the CCG and national average of 89%.
- 73% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 86% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 66% said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 84% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 90%.
- 90% said the nurse gave them enough time compared to the CCG average of 91% and national average of 92%.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey we reviewed showed patients did not always respond positively to questions about their involvement in planning and making decisions about their care and treatment and results were below local and national averages. For example:

- 70% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.
- 62% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%

When asked about their involvement in planning and making decisions about their care and treatment, patients we spoke with on the day informed us this depended on

Good

Are services caring?

which GP they were seen by. There was a trend around negatively focussed comments towards one of the GPs. However, an equal amount of positive comments were made about this GP, around how patients preferred to see this GP and that the GP had provided good personal care. Where there had been complaints around GP bedside manners and behaviour the practice manager had brought this to the attention of the GP. We saw no other measures were undertaken in response to the relatively low score on the involvement of decisions about patients' care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and there was information available in multiple languages through the practice website.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting rooms 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. There was a practice register of all people who were carers and 114 patients on the practice list had been identified as carers and were being supported, for example, by offering health checks and referral for organisations such as social services for support. Written information was available for carers to ensure they understood the various avenues of support available in the practice's waiting room and on their website.

Staff informed us that if families had suffered bereavement GP contacted them. This was either followed by a patient consultation and/or by giving them advice on how to find a support service. The practice had drafted a bereavement protocol to ascertain that all staff took a similar approach when bereavement occurred. This protocol also outlined how staff and systems would be kept up to date if a patient passed away.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice was aware of future challenges, an increase in local housing development had the potential to impact on the provision of services at the practice. The practice continually monitored the impact of challenges on the provision of its service.

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

- The practice offered bookable appointments early mornings from 0730 every weekday, except Tuesday, for all patients including working patients who could not attend during normal opening hours.
- Extended appointments were available, to provide patients requiring so, the opportunity to discuss their health care needs. For example, there were longer appointments available for people with a learning disability.
- Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available and there was information available in multiple languages through the practice website.
- Staff at the practice spoke several languages, with one GP able to speak Finnish, German, Spanish, Swedish and basic Russian. We were told that occasionally this would enable the GP to hold consultations in a patient's preferred language.
- The practice's patient signing in screen displayed four different languages.
- Parking was available and included spaces for disabled patients with level access. Entrance doors were not automatic, however we saw an external doorbell was available for patients to call for assistance should they need support accessing the building. Disabled facilities were available but we found that the reception desk was too high to be used effectively by patients that were wheelchair bound.
- The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. For example, home visits were available for patients who were housebound because of illness or disability.
- Urgent access appointments were available for children and those with serious medical conditions.
- GPs at the practice had special interests in different clinical fields, including rheumatology, diabetes, asthma, adolescent medicine and sexual health.
- All registered patients had been allocated a named, accountable GP.
- There were baby changing facilities available.
- The practice worked closely with multidisciplinary teams to improve the quality of service provided to vulnerable and palliative patients. This included the Gold Standard Framework working in which the practice was proactive.
- Online appointment booking, prescription ordering and access to basic medical records was available for patients.
- One of the GPs was a lead for the local clinical commissioning group (CCG) for peer review of CCG referrals and involved in the development of new patient referral pathways.
- The practice offered a variety of clinics, including minor surgery, sexual health, post-operative wounds and minor injury.

Access to the service

The practice operated generally between the hours of 0800 and 1800, Monday to Friday. Appointments were from 0800 to 1230 and 1330 to 1800 every weekday. With early morning appointments from 0730 on every weekday except Tuesday. In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them. For these, the practice offered telephone triage through a system where a receptionist would take certain details on a patient's reason for calling after which the GP would contact the patient over the phone for consultation, request them to visit the practice or provide advice via the reception.

People we spoke with on the day told us they were able to get appointments when they needed them. Of the seven comment cards we received two contained positive comments around the availability of appointments and

Good

Are services responsive to people's needs?

(for example, to feedback?)

these being on time. Results from the July 2015 national GP patient survey showed that patient's satisfaction with how they could access care and treatment was low in comparison to local and national averages. For example:

- 66% of patients were satisfied with the practice's opening hours compared to the CCG and national average of 75%.
- 65% of patients said they could get through easily to the surgery by phone compared to the CCG and national average of 73%.
- 62% of patients described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 56% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints' policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. A policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. We looked at a log of 53 complaints received in 2014/2015. Records showed complaints had been dealt with in a timely way. Monthly complaints review meetings took place and complaints were categorised to assess trends, this included verbal complaints. For example, we saw that from a recent complaints' review the practice had received four complaints around communication and attitude. In response, the practice had discussed bedside manner and consultation skills with the GP. The practice cascaded relevant learning from complaints to staff at regular practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

We saw that information was available to help patients understand the complaints system for example information was available in the practice and on the practice website, summary leaflets were available.

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 vision of delivering a first class medical service to the local population and to provide a service that fully satisfied the needs and expectation of patients whilst respecting their individuality and confidentiality. The practice aimed to be a contributor in care planning, respond positively to patient feedback and to protect staff and patients from hazards and abuse. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and all staff we spoke with felt supported by management. Clinical staff felt supported in their decision making process whilst administration staff confirmed effective induction processes.

The practice provided us with a practice plan for 2015/2016 and beyond. This plan was presented in the form of a SWOT –strengths, weaknesses, opportunities and threats- analysis and addressed a variety of these subjects in a structured way. For example, the growth of housing and population over the next decade.

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. For example:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- The GPs were supported to address their professional development needs for revalidation.
- Staff were supported through appraisals and continued professional development. The GPs had learnt from incidents and complaints.
- There was a comprehensive list of internal meetings and training sessions that involved staff both in a formal and informal setting. Patients and procedures were discussed to improve outcomes.
- From a review of records including action points from staff meetings, complaints and significant event recording, we saw that information was reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and to identify and manage risk.
- GPs had undertaken clinical audits which were used to monitor quality and systems to identify where action should be taken and drive improvements. These included an osteoporosis fragility fractures audit which concluded that some patient medication dosages needed to be changed.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The practice management team were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. Staff told us that regular team meetings were held and there was an open culture within the practice. Staff said they had the opportunity to raise any issues impromptu or at team meetings, were confident in doing so and felt supported if they did.

We reviewed a number of policies, for example the whistleblowing policy, recruitment policy and chaperone policy which were in place to support staff and up to date. Staff we spoke with knew where to find these policies if required. It was clear from our interviews with the GPs, the management team and the staff that there was an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first. Staff members we spoke with told us they felt their contribution to providing good quality care was valued.

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

The practice encouraged and valued feedback from patients, proactively gaining their feedback and engaging patients in the delivery of the service. It had gathered

Are services well-led?

Good

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

feedback from patients through the website, patients' complaints and compliments and by having a feedback box in the waiting room. The practice had also recently set up a patient participation group (PPG). This was an active virtual PPG, this group did not meet on a regular basis nor had carried out patient surveys, but the practice manager informed us he welcomed meetings if requested. The practice website invited patients to become involved with their PPG.

The practice had introduced the NHS Friends and Family test (FFT) as another way for patients to let them know how well they were doing. For example, 2015 FFT data available to us showed that:

- In April, from 68 responses, 69% recommended the practice compared to 88% nationally.
- In June, from 47 responses, 81% recommended the practice compared to 88% nationally.
- In July, from 82 responses, 76% recommended the practice compared to 88% nationally.

In response to feedback on NHS Choices (34 comments) the practice manager had undertaken an analysis of feedback, taking in consideration information from 50 returns of the Friends and Family Test (FFT) since January 2015 and comparing this to the structure of NHS Choices feedback. This had led the practice to conclude that the FFT feedback turned out more positive than the NHS Choices feedback (overall, out of 5 stars: 4.2 versus 1.0). Though we are not able to clarify or validate this data, it is evidence that the practice was proactive in analysing feedback.

The practice had also gathered feedback from staff through staff training days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

The practice had completed reviews of incidents, compliments and complaints. Records showed that regular clinical and non-clinical meetings and audits were carried out as part of their quality improvement process to improve the service and patient care. Completed audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment. Where audits had taken place these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. For example, one member of staff could work both in the reception and as a phlebotomist. The staff we spoke with felt well supported and felt that their training needs were being met. The practice staff told us they worked well together as a team and there was evidence that staff were supported to attend training appropriate to their roles.