Dr Encarnacion Ruiz-Gutierrez

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Encarnacion Ruiz-Gutierrez

on 30 August 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed. However the practice should regularly review significant events and ensure staff had read all practice policies.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. However we did not see any information on display for patients about the interpreting service. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. However the practice needed to increase opportunities to seek and act on feedback from patients for the purposes of continuous evaluation and improvement of the service.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- Carry out regular reviews of significant events to aid in the identification of trends.

Summary of findings

- Review accessibility of the emergency alarm switch/ process for alerting staff to an emergency in the disabled toilet.
- Ensure staff have read practice policies to ensure they are being correctly implemented.
- Ensure fire risk assessments include details of actions taken and the due date.
- Take appropriate action to bring the availability of interpreting services to patient's attention.
- Improve opportunities to seek and act on feedback from patients for the purposes of continuous evaluation and improvement of the service.
- Keep a copy of the business continuity plan off site.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice had worked with the CCG to improve breast and bowel cancer screening rates.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

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

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Older people were given priority for telephone consultations and home visits.
- Care plans for high risk patients were regularly reviewed.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Quality and Outcomes Framework (QOF) performance in 2014/15 for diabetes related indicators was 92% which was in line with the CCG average of 86% and the national average of 89%.
- A multi-disciplinary diabetes meeting was held every two months.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Targeted vaccination campaigns were held for flu with drop-in clinics held on Saturdays at the beginning of the season to maximise uptake.

Families, children and young people

Good

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

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 80% which was comparable to the CCG average of 81% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Children under five years were prioritised for appointments.
- We saw positive examples of joint working with midwives, health visitors and school nurses. The health visitor attended the practice regularly to see patients.

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.
- Early morning appointments (8am) were available depending on demand.
- Late evening and weekend appointments were available at one of a number of local GP hub sites.
- 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.
- Human papilloma virus (HPV) vaccine was provided and the practice participated in national immunisation campaigns for students.

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 homeless people, travellers and those with a learning disability.

Summary of findings

- The practice offered longer appointments for patients with a learning disability, who received regular reviews.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Patients at risk of A&E attendance were identified and flagged and care plans were developed. They were also prioritised for appointments

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 percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 87% which was comparable to the CCG average of 84% and the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- A severe mental illness liaison and consultant psychiatrist attended the practice regularly to see patients.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with local and national averages. 359 survey forms were distributed and 93 were returned. This represented 3% of the practice's patient list.

- 67% of patients found it easy to get through to this practice by phone compared to the CCG average of 60% and the national average of 73%.
- 73% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 76% and the national average of 85%.
- 78% of patients described the overall experience of this GP practice as good compared to the CCG average of 75% and the national average of 85%.
- 73% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 66% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 39 comment cards most of which were positive about the standard of care received. Respondents commented on the high standard of service they received and cleanliness of the environment. They reported that staff were friendly and caring. A few patients reported dissatisfaction with getting through on the telephone and getting early or late appointments for working people.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Results of the most recent friends and families test showed that 88% (eight out of nine) respondents would recommend this practice.

Dr Encarnacion Ruiz-Gutierrez

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Encarnacion Ruiz-Gutierrez

Dr Encarnacion Ruiz-Gutierrez (also known as St. Lukes Medical Centre) is a GP practice located in a residential area of Canning Town, a town in the London Borough of Newham, to the east of London. The practice is one of two GP practices and a café situated within St Luke's, a converted church which was built in 1875. Restoration of the building began in 1995, led by a charity formed by local people. The building is fully accessible and parking is available on surrounding streets. The practice is well served by public transport links.

Newham's population is one of the most ethnically diverse in London. In 2009, 65% of residents were recorded as being non-white. Of these 21% were Pakistani or Bangladeshi, 18% were Black, 11% were Indian and 14% were either of mixed ethnic origin or from another non-white ethnic group. Newham residents have lower life expectancy and higher rates of premature mortality than other Boroughs in London and the average for England as a whole. The main causes of death in Newham are cardiovascular disease, cancer and respiratory disease and the levels of diabetes are among the highest in the country. Newham is the third most deprived local authority area in England. The area has a higher percentage than national average of people whose working status is unemployed (13% compared to 5% nationally) and a lower percentage of people over 65 years of age (7% compared to 17% nationally).

Despite its proximity to the City of London, Canning Town is in the second most deprived decile out of ten on the deprivation scale. People living in more deprived areas tend to have greater need for health services. The practice profile shows a higher than average number of patients aged from 20 to 39 years. Life expectancy data for the locality shows that life expectancy for men is 75 years, which is below the national level of 79 years. For women life expectancy is 81 years which is below the national level of 83 years. Canning town is currently undergoing significant regeneration with thousands of new homes and improved infrastructure planned.

The practice was started in 2009 by Dr Ruiz (female, five sessions) who formed a partnership with Dr Joarder (male, seven sessions) in 2015. Prior to this he had been a long-term locum. Other staff include a nurse practitioner, practice manager, four reception/administrative staff and a summariser. The practice provides services to around 4200 patients under a General Medical Services contract (GMS).

The practice's opening hours are 8am to 6pm every weekday except Thursday when it closes at 1pm. Consultation times vary by clinician but are generally from 9am to 12.30/1pm and 3pm to 6pm Monday to Friday except Thursday when they are from 9am to 12pm. A walk in service is available every Monday. Outside of these hours patients are directed to the out of hours service or the extended hours service. Extended hours appointments are

available every day from 6.30pm to 8.30/9pm daily except Saturday when the times are 9am to 1pm at one of nine local GP practices. Out of hours patients are also directed to the local urgent care centre which is open from 8am to 11pm daily.

The practice was inspected under our previous inspection regime in 2013 and was found to be compliant with the regulations.

Dr Encarnacion Ruiz-Gutierrez is registered with the Care Quality Commission to carry on the regulated activities of Family planning; Diagnostic and screening procedures; Treatment of disease, disorder or injury and Maternity and midwifery services from St Lukes Health Centre, London, Newham, E16 1HT.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30 August 2016. During our visit we:

- Spoke with a range of staff including GPs, nurse and administrative/receptionist staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Whilst significant events were reviewed and discussed on an individual basis, the practice did not carry out a thorough analysis of significant events to identify any trends.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. One example related to an error whereby an electro cardiogram (ECG) report for one patient was scanned into the notes of another patient with a similar name. The error was rectified when it was noticed by the same member of staff who had made the scanning error. We saw evidence that the incident was investigated and discussed at a team meeting. Learning was shared and appropriate action was taken to prevent a recurrence. Measures included adding a major alert to the computer database when staff noticed patients with similar names or identifying data and reviewing scanning protocols to make scanning an isolated task. It was also decided that staff must always check two identity references before filing documents.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff, The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3. The nurse was trained to level 2 and non-clinical staff to level 1 or 2.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who 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. The most recent infection control audit was carried out in March 2016 and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Where there were any alerts on the script or patient's notes such as where reviews were necessary or where the prescription was for controlled drugs, these were given to a GP to process.
- Patients were encouraged to use the electronic prescription service (EPS) which was used by the majority of its patients. The practice carried out regular medicines audits, with the support of the local CCG

pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. They were emptied from the printers and locked away at the end of each day and replaced every morning. Batch numbers allocated to each GP were recorded on a register which was signed by each GP.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The landlord had responsibility for fire safety procedures which included testing fire alarms, equipment and emergency lighting. We saw that these had been carried out recently. The practice had up to date fire risk assessments however the most recent risk assessment did not state what actions had been taken following the assessment and when they were due.
- We noted the emergency alarm switch in the disabled toilet was tied up in such a way that it could be inaccessible to a disabled person.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Where a GP locum was required the practiced tended to use the same locum who was familiar with the practices processes and policies. The practice had a suitable locum pack available.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the nurse's room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All emergency equipment was checked regularly and these checks were recorded. Emergency medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The practice had a reciprocal arrangement with another practice to share their premises in the event of theirs becoming unusable. A copy of this plan was not kept off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Guidelines are disseminated to all relevant staff by the lead GP and copies were stored on the computer system.
- 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 used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available with an exception reporting level of 7% which was similar to the CCG and national averages of 7% and 9% respectively. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

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

- Quality and Outcomes Framework (QOF) performance in 2014/15 for diabetes related indicators was 92% which was in line with the CCG average of 86% and the national average of 89%.
- Quality and Outcomes Framework (QOF) performance in 2014/15 for mental health related indicators was 88% which was in line with the CCG average of 87% and the national average of 93%.

There was evidence of quality improvement including clinical audit.

- There had been two clinical audits completed in the last two years, both of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, one of the audits was to increase the use of anticoagulants and reduce the inappropriate use of antiplatelet agents (medicines which lower the risk of clots forming in the blood). In the first audit ten patients were identified against set criteria. Following the audit the practice identified a group of patients that needed anticoagulants/ antiplatelet treatment review. Four of the patients were referred for anticoagulation consideration, four declined to be referred and no further action was taken for two patients on clinical grounds . All of the patients continued to be monitored with the aim of stroke prevention management.
- The audit was repeated two years later. Nine patients were reviewed.The results showed that all patients' thromboprophylaxis (measures taken to prevent blood clots) was managed according to NICE recommendations.Six patients declined to take anticoagulants after receiving medical advice. Appropriate risk assessments were carried out.
- A third audit was carried out a further two years later this time involving 25 patients. After completing this audit it was identified that all patients were still being managed according to previous NICE recommendations. Nine patients had been initiated on suitable medication and six were identified as "high risk" or were not compliant with medication. They were highlighted for closer monitoring. The others had either declined medication or it was deemed inappropriate on clinical grounds.
- The audit was ongoing at the time of our inspection and the practice was able to demonstrate how, through this audit, they had performed well in the category of estimated diagnosis for Atrial Fibrillation (irregular heart rhythm).

Information about patients' outcomes was used to make improvements. For example the practice was aware that patients on aspirin were two to three times more likely to have a stroke as people on warfarin. Therefore, through the

Good

Are services effective?

(for example, treatment is effective)

audits they identified patients who had been using Aspirin on a long term basis and carried out reviews to assess whether warfarin or a new oral anticoagulant (NOAC) might be more appropriate.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, administering vaccines and taking smear test samples.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and new mothers. Patients were signposted to the relevant service.
- A dietician was available on the premises and smoking cessation advice was available from a local support group.
- The CCG ran weekly sessions for pre-diabetic patients to which patients were referred by the practice. Workshops were run for patients with long term conditions who required help to eat more healthily.

Good

Are services effective?

(for example, treatment is effective)

- The practice referred first time mothers to nursing partnership programmes for first time mothers where mental and social support was offered.
- Patients requiring advice and support for drug misuse were referred to a local service.
- Patients at risk of unplanned admissions to hospital were referred to Care Navigators who provided extra support to help patients to stay at home.

The practice's uptake for the cervical screening programme was 69%, which was comparable to the CCG average of 69% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccines given were below CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 5% to 78% (CCG average 6% to 94%) and five year olds from 48% to 84% (CCG average 82% to 95%). The practice was aware that this was an area of challenge for them and told us this was an area wide issue. We were told there were some educational and cultural issues that were impacting on the up take of childhood immunisations in the local area. The practice had dedicated specific reception/administrative staff to manage this area. They were responsible for contacting parents who did not bring their children for immunisation and encouraging them to attend. The health visitor attended the practice monthly and any patients of concern were brought to their attention.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 39 comment cards most of which were positive about the standard of care received. Respondents reported that staff were friendly and caring and treated them with dignity and respect. We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 82% and the national average of 89%.
- 80% of patients said the GP gave them enough time compared to the CCG average of 78% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and the national average of 95%.
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 77%and the national average of 85%.
- 81% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 81% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 80% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and the national average of 86%.
- 75% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and the national average of 82%.
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 77% and the national average of 85%.

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

- Staff told us that interpreting services were available for patients who did not have English as a first language. Both GPs were able to speak a number of European and Asian languages.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

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

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 167 patients as carers (4% of the practice list). Carer's details were included in patients' records and care plans. Carers were prioritised for appointments. They were discussed at multi disciplinary team (MDT) meetings to ensure they were referred for support. Written information was available to direct carers to the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Clinical staff attended monthly CCG meetings to discuss local health challenges. For example, the practice had worked with the CCG to improve breast and bowel cancer screening rates. We saw notices on display in reception alerting patients to the importance of screening. Representatives from the CCG attended the practice, identified relevant patients from the computer system and contacted them directly. The practice was also involved in the CATAPULT Trial (Completion and Acceptability of Treatment Across Primary Care and the community for Latent Tuberculosis). The trial involved testing patients who were new arrivals to the country for latent TB. Those who tested positive were referred for further treatment.

- The practice offered late appointments (6.30pm to 8.30/9pm Monday to Friday and 9am to 1pm on Saturday) through a hub of local GPs for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available. The partners both spoke a number of European and Asian languages.
- Patients with limited mobility were only seen in the "easy access" rooms.
- An electronic check in machine was available although it was out if service on the day of the inspection.

Access to the service

The practice's opening hours were 8am to 6pm every weekday except Thursday when it closed at 1pm.

Consultation times varied by clinician but were generally from 9am to 12.30/1pm and 3pm to 6pm Monday to Friday except Thursday when they were from 9am to 12pm. A walk in service was available every Monday. Outside of these hours patients were directed to the out of hours service or the extended hours service. Extended hours appointments were available every day from 6.30pm to 8.30/9pm daily except Saturday when the times were 9am to 1pm at one of nine local GP practices. Out of hours patients were also directed to the local urgent care centre which was open from 8am to 11pm daily. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

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

- 69% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 67% of patients said they could get through easily to the practice by phone compared to the CCG average of 60% and the national average of 73%.

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

The practice had a system in place to assess:

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

Patients were asked to contact the practice by 10am to request a home visit following which the GP contacted the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the practice leaflet, on the practice website and on display in reception.
- The practice was aware of some negative feedback on NHS Choices about receptionists. We saw that some of these comments had been responded to. The practice had taken steps to address this issue through recruitment and training. Feedback from patients we spoke to demonstrated improvements in this area.

We looked at eight complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, following a complaint about an error in vaccine administration an investigation took place, followed by a meeting with the patient and senior staff. Advice was sought from the immunisation team and appropriate action was taken to ensure the patient hadn't experienced any side-effects. Action taken included the practice nurse attending immunisation update training, the separation of the relevant vaccines within the fridge and the completion of an immunisation audit within the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

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

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The partners had supported the practice nurse to qualify as a nurse prescriber the previous year. She was and continued to be mentored by the lead GP and we saw that regular supervision took place.

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

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

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

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

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG), NHS Choices and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. For example, the PPG had raised concerns with the practice about changes to the eye testing procedures locally which meant patients had

Are services well-led?

Good

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

to travel much further for their eye tests. The lead GP had communicated this concern to the CCG and NHS England and the service was relocated to closer to the practice.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, where reception staff had noted high demand for earlier appointments, they had fed this back to the management and some 8am clinics had been run as a result. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was aware of the projected growth in need for GP services in the local area due to the large scale gentrification that was underway. It was in negotiations with the CCG for larger premises at the time of our inspection.