Dr Peter Chadwick

Quality Report

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Date of inspection visit: 30/07/2015
Date of publication: 24/09/2015

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Burnage Healthcare Practice on 30th July 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed with the exception of a system to check that changes were effective when things went wrong.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and training needs were discussed regularly at practice meetings.
- 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.
- Patients said they found it easy to make an appointment with a named GP and 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Each member of staff had been given a personal notebook by the GP and asked to record ideas, suggestions of any risk assessments and examples of good practice in order to indicate a culture of improvement. These had been in place since February 2015 and staff were finding them useful.

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

Importantly the provider should :

Summary of findings

- Ensure they complete their revalidation and update their safeguard training;
- Undertake training in order to support patients under the Mental Capacity Act 2005 Code of Practice;
- Introduce a system to check that actions that arise out of significant events, complaints, comments or audits, are implemented and are effective.
- Prepare and implement an induction pack for locum staff;

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored and addressed. Risks to patients were assessed and well managed with the exception of routine reviews to check that actions required were carried out and re-occurrence of the risk had been reduced. The practice should introduce a system to check that changes to practice have been implemented and are effective.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed most patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and most care was planned and delivered in line with current legislation. This included promoting good health. Staff worked with multi disciplinary teams and documented discussions.

There was evidence of appraisals and personal development plans for all staff and staff had received training appropriate to their roles. Further training needs were identified at team meetings on a weekly basis. to the GP needed to complete their revalidation, update their safeguard training and complete training under the Mental Capacity Act 2005 to better support patients with mental capacity issues.

Are services caring?

Good

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

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 found it easy to make an appointment with a

Summary of findings

named GP and 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 and other stakeholders.

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 proactively sought feedback from staff and patients, which it acted on. A virtual patient participation group (vPPG) was active. Staff, with the exception of locum GPs, 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 offered enhanced services in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The percentage of older people (aged 75+) registered at the practice was small and was lower than the national average.

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. Longer appointments and home visits were available when needed. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients falling within this category had the benefit of a sole GP who knew them well and understood their conditions. The practice staff were pro-actively improving and introducing systems to ensure that patients within this group received appropriate follow up.

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 who had a high number of A&E attendances. Immunisation rates were comparable for all standard childhood immunisations. Staff 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 times and a dedicated, open access, baby clinic was available once a week.

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

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable because action was required by the GP. There were systems to identify patients living in vulnerable circumstances and a register of those with a learning disability who received regular health checks and longer appointments when required. Staff were trained and gave good examples where they had recognised signs of abuse or vulnerability in adults and children. Staff were aware of their responsibilities to document information and we saw examples where they had shared information with other relevant agencies. However, action was required by the GP to undertake safeguard training at the appropriate level.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia) because action is required by the GP. 88% of people experiencing poor mental health had a structured plan in place and had been reviewed in the last twelve months. The practice regularly worked with other health and social care professionals in the case management of people experiencing poor mental health. A directed enhanced service was in place to facilitate the timely diagnosis and support for patients with dementia. However, action was required by the GP to complete training under the Mental Capacity Act 2005 in order to better identify and support patients who lacked capacity to make decisions.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2nd July 2015 showed the practice was performing above local and national averages. There were 93 responses which represented 4% of the practice population.

- 96% find it easy to get through to this surgery by phone compared with a CCG average of 67% and a national average of 73%.
- 94% find the receptionists at this surgery helpful compared with a CCG average of 85% and a national average of 87%.
- 86% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 58% and a national average of 60%.
- 97% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 83% and a national average of 85%.
- 96% say the last appointment they got was convenient compared with a CCG average of 92% and a national average of 92%.
- 95% describe their experience of making an appointment as good compared with a CCG average of 69% and a national average of 73%.
- 67% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 62% and a national average of 62%.
- 74% feel they don't normally have to wait too long to be seen compared with a CCG average of 55% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients. We received 43 comment cards which were all positive about the standard of care received. The key points described the service as excellent, stating that staff were understanding, friendly and accommodating. Patients commented that they were always able to get an appointment, felt listened to and were treated with dignity and respect in a safe and pleasant environment. Three patients gave negative comments about the GPs manner toward them.

We spoke to seven patients who all gave positive comments about the practice, the staff and the GP. They said the service they received was good and they had no problems. One patient commented that an additional GP would be beneficial and one patient, although happy with the service, felt that they were not always listened to properly.

Areas for improvement

Action the service SHOULD take to improve

- Ensure they complete their revalidation and update their safeguard training;
- Undertake training in order to support patients under the Mental Capacity Act 2005 Code of Practice;
- Introduce a system to check that actions that arise out of significant events, complaints, comments or audits, are implemented and are effective.
- Prepare and implement an induction pack for locum staff;

Dr Peter Chadwick

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an expert by experience. An expert by experience is someone who uses health and social care services.

Background to Dr Peter Chadwick

Burnage Healthcare Practice is a long established GP surgery. It is independent to, but occupies the same building as Burnage Community Health Centre. The centre was purpose built in 1995 with the GP's input and the practice has been there since the building was opened. There is on-site disabled car parking, disabled access and disabled facilities within the practice.

The practice offers services to 2,300 patients within Burnage and the surrounding area of Heaton Mersey under a general medical services contract.

The lead GP is the sole, male GP available for nine two hour surgeries per week and a locum female GP attends for one two hour surgery on a Friday afternoon. The practice nurse (female) is available each morning between 9.30am and 12.45 and on a Tuesday afternoon between 4pm and 6pm. The surgery is open and reception staff are available Monday to Friday from 8.30am until 1pm and from 2pm until 6pm. The surgery is closed for an hour each lunch time and does not re-open on a Wednesday afternoon. When the practice is closed patients are directed to the Out of Hours Service covered by Mastercall Healthcare.

Why we carried out this inspection

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

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

Detailed findings

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

For example:

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30th July 2015. During our visit we spoke with a range of staff including the GP, nurse and administration staff. We observed how people were being cared for, talked with seven patients and reviewed some examples of evidence on the electronic patient system We reviewed 43 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 a system in place for reporting and recording significant events. Staff told us they would inform the practice manager and GP of any incidents and there was also a form available on the practice's computer system that all staff used. Complaints received by the practice were recorded, discussed and addressed appropriately.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. 18 significant events had been recorded in the last 12 months, most of which were administrative rather than clinical errors. Lessons were shared and appropriate actions were suggested but there was no review to check that actions were taken or that they were effective in reducing any future re-occurrence.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The GP was aware of their responsibility to report major incidents to the Clinical Commissioning Group (CCG), Care Quality Commission (CQC) and/or Healthwatch. The GP told us that no such incidents had occurred.

Overview of safety systems and processes

The practice were able to demonstrate a safe track record through risk management systems such as safeguarding, health and safety procedures, infection control, medicines and equipment management and staffing.

- Arrangements that reflected relevant legislation and local requirements were in place to safeguard adults and children from abuse. Up to date policies and procedures which clearly outlined who to contact for further guidance were available to all staff to refer to if they had concerns about a patient's welfare. Safeguarding was not a regular agenda item on practice meetings but minutes we reviewed evidenced that discussion took place when required. All staff spoken with demonstrated that they understood their roles and responsibilities in this area and provided examples where concerns were shared with the CCG or other appropriate agencies. All staff apart from the GP had received training relevant to their role. The GP was safeguarding lead, but had not completed the required level 3 training since 2012.
- A notice was displayed in the waiting room, advising patients of their right to a chaperone if and when required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring service 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).
- There were procedures in place for monitoring and managing risks to patients and staff. There was a health and safety policy available and staff had reviewed it recently. The practice had up to date fire risk assessments and regular fire drills were carried out. 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 also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and regular flushing of taps to ensure that legionella was not a risk.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and 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 relevant training and information by the practice nurse. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medicine 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. The practice monitored its use of hypnotics (which were higher than average) and were working on a reduction regime with patients. Prescription pads and

electronic sheets were securely stored in lockable cupboards but a system was required to monitor and log the serial numbers of prescriptions order, received and used.

- We reviewed four staff files which showed that appropriate recruitment checks had been undertaken prior to employment. For example, each file held proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number and mix of staff required 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 to provide the required service and administration staff were able to cover some elements of each other's role. A guidance folder had been introduced for non-clinical staff to refer to about jobs they might undertake on behalf of another colleague. However there was little documented instruction about each person's role if cover was required in the event of long term planned or unplanned absence.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and were adult, child and baby certified. There were emergency medicines available in the treatment room and the practice was responsible for checks to ensure they were in date and fit for use. The practice had a defibrillator available on the premises and oxygen with masks for adults and children. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with current evidence based guidance and standards, relevant to patients' needs. These included best practice and guidelines from National Institute for Health and Care Excellence (NICE). The GP and practice nurse received information direct to their mailbox and discussed and shared it at meetings to keep all clinicians up to date. The practice used the information to develop how care and treatment was delivered to meet needs which they demonstrated through examples such as changes in practice around alcohol misuse and nonsteroidal anti-inflammatory drugs (NSAIDs). The practice monitored that these guidelines were followed through audits and random sample checks of patient records. The practice provided a directed enhanced service to facilitate the timely diagnosis and support for patients with dementia. However, action was required by the GP to complete training under the Mental Capacity Act 2005 in order to better identify and support patients who lacked capacity to make decisions.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We reviewed the most recent QOF results (2013/14) for the practice which showed that 94.8% of the total number of points were received with 11.5% exception reporting. The practice was not an outlier for any QOF (or other national) clinical targets. Data from our intelligent monitoring showed;

- Performance for diabetes related indicators were similar to expected for the CCG and national average with the highest indicator showing 94%
- The percentage of patients with hypertension having regular blood pressure tests was similar to expected the CCG and national average at 82%
- Performance for mental health related indicators were similar to expected for the CCG and national average with the highest indicator showing 99%
- The dementia diagnosis rate was similar to expected for the CCG and national average at 89%

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been several clinical audits completed in the last two years and we reviewed two of those. One related to the prescribing of hypnotic medicines and we saw where the improvements made were implemented (patients were undergoing a reduction regime) and monitored, showing that positive outcomes were being achieved.

Findings from audits were used by the practice to improve services. For example the GP had completed two data collections around the effectiveness of joint injections. The audit showed that the effectiveness of the injection and recording of the drug used met the standards set. However the audit identified the recording of consent for those procedures was low. A new system had been implemented to ensure that consent was recorded and the results had improved from 10% to 72%.

The practice participated in applicable local audits and research. Information from NICE guidelines had been used to monitor the medicines of patients who misused alcohol and other patients on nonsteroidal anti-inflammatory drugs (NSAIDs) had been called in for a review and change of their medication where appropriate.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. There had not been any recruitment of non-clinical staff for more than three years. However there was no induction for locum GPs who attended to work at the practice more frequently.
- Staff received annual appraisals and informal support from their colleagues and senior management whenever it was required. Learning needs were identified opportunistically and staff had access to appropriate training to meet those needs.
- Staff received training that included: safeguarding, fire procedures, basic life support and information

governance awareness. Staff had access to and made use of e-learning training modules and in-house training. Action was required by the GP with regard to their training needs.

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 test results. Information such as NHS patient information leaflets was also available. Relevant information was mostly shared with other services in a timely way, for example when patients were referred to or from other services. We saw examples where delays had occurred. The GP was aware of these delays, through complaints or significant events and was changing practice to reflect them.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were used in some circumstances. Where care plans were in place they were reviewed and updated as required.

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 but there was no formal training around mental capacity. The practice nurse had completed an on-line module of the Mental Capacity Act 2005 in March 2015. The GP had not completed any formal training and had a limited understanding around ways to identify and support patients with capacity issues. When providing care and treatment for children and young people, assessments of capacity to consent were carried out in line with relevant guidance. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, those requiring advice on their diet, smoking and alcohol cessation and those who were vulnerable. Patients were then signposted to other relevant services or given advice by the practice nurse on diet and smoking cessation. There was a clinical and non clinical cancer champion and patients with cancer who may be in need of extra care were also identified and received the relevant advice and support.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme, for 2013/2014, was lower than expected in comparison to the CCG average and national average. The practice had identified the lower figures and taken steps to directly contact those patients who had failed to attend. This was ongoing and the practice was able to demonstrate that the figures had increased. They had also taken steps to increase figures for the recording of smoking cessation advice (which was now at 98-99%) and to identify patients who may have diabetes.

The virtual Patient Participation Group had commented that a better recall of patients for health checks could be in place. The practice had reviewed the suggestions and taken action to make change. The nurse was continuing to monitor the uptake of all patients and increase attendance for follow ups where required. This was being done opportunistically until a formal process could be introduced and implemented.

Childhood immunisation rates for the vaccinations given were to under two year olds and five year olds ranged from 89% to 95%, flu vaccination rates for the over 65s was at 70% and for those at risk was 60%. These figures were comparable to CCG and national averages.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All but four of the 43 patient CQC comment cards we received were positive about the service experienced. Patients we spoke to said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. The negative comments related to dissatisfaction with the manner of the GP during consultations.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was lower in some responses and higher in others compared to the CCG and national figures for its satisfaction on consultations with doctors and nurses. For example:

- 84% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 80% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 92% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 86% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90%.
- 94% patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

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 responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages although some of the figures were lower than the CCG and national averages. For example:

- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room 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 10 patients of the practice list had been identified as carers and were being supported, for example, by providing assessments, offering health checks and referral for social services support when necessary. The practice nurse was responsible for keeping the information

Good

Are services caring?

up to date and following up any new carers identified. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff and patients told us that if families had suffered bereavement, they were supported by the practice and the GP. The GP telephoned them and offered an appointment if necessary. Staff at the practice had been employed for many years and were very familiar with the needs of the patients. Leaflets and information on the practice website signposted patients to other support services.

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 Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. The CCG medicines management team attended the practice regularly to provide advice and changes about medicines and the practice made changes where required. The infection control team carried out audits and advised on any actions to be taken. The GP attended local patch meetings with other practices to share outlying performance and best practice and palliative care meetings were held once a month where patients needs were discussed and adjusted when required.

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

- There were longer appointments available for people with a learning disability or other patients, such as those with mental health issues or complex needs.
- Home visits were available for older patients or patients who were housebound.
- Urgent access appointments were available on a daily basis and we saw evidence of this.
- There were disabled facilities and translation services available and the premises were accessible to people using wheelchairs and prams. Breast feeding and baby changing facilities were available in the healthcare centre.
- Electronic prescribing had been implemented.
- A dedicated clinical and non-clinical cancer champion was available and an Infostand with various booklets was accessible in a dedicated corner of the waiting room.
- There was information to let patients know that they could discuss matters in private if they wished and there was a room available for this. The practice had also prepared slips of paper with sensitive questions that could be handed to patients rather than speaking out loud.
- A scrolling information and message board which was controlled by the practice who updated it with relevant and current information.

Access to the service

Dr Chadwick was the sole, male GP available for nine two hour surgeries per week and a locum female GP attended for one two hour surgery on a Friday afternoon. The practice nurse (female) was available each morning between 9.30am and 12.45 and on a Tuesday afternoon between 4pm and 6pm. The surgery was open and with reception staff available Monday to Friday from 8.30am until 1pm and from 2pm until 6pm. The surgery closed for an hour each lunch time and did not re-open on a Wednesday afternoon. When the practice was closed patients were directed to the Out of Hours Service covered by Mastercall Healthcare.

Urgent appointments were available on a daily basis (morning and afternoon) and appointments could be booked up to two weeks in advance.

There were no extended hours surgeries offered by the practice but patients could access medical assistance at the local walk in centres daily between 08.30am until 10pm including weekends and bank holidays.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment was what the practice did best compared to local and national averages. Patients we spoke to on the day were able to get appointments when they needed them. For example:

- 79% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 96% patients said they could get through easily to the surgery by phone compared to the CCG average of 67% and national average of 73%.
- 95% patients described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73%.
- 67% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available on the practice website, patient leaflet and practice charter to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at three formal complaints received and recorded in the last 12 months and found that they were satisfactorily handled and dealt with in a timely way. Patients had been signposted to other agencies that could help them, such as the ombudsman or patient advice liaison service (PALS) and the practice were open and transparent when dealing with the complaints. The GP had responded to comments left on NHS choices and advised patients that they could come to the practice to discuss their concerns.

Staff told us that the majority of patient issues, comments and concerns were discussed and resolved informally and were not recorded. However we saw that if actions were required these were discussed at practice meeting and changes were made to working practice when necessary. We saw an example where a new system had been applied which alerted the GP to matters that required urgent attention. This had been agreed following delay to a patient's change of medicine.

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 detailed in the patient leaflet which were accessible in the waiting area. Staff knew, understood and upheld the values. Staff reported that there was a clear planning process, discussed through regular meetings and they felt encouraged to influence future plans.

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
- There was a comprehensive understanding of the performance of the practice
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements

We saw that there were arrangements to identify, record and manage risks with required actions. We saw some examples where actions had been implemented and a change in working practice had taken place. However, the practice should introduce a system to check that all actions arising out of significant events, complaints, comments or audits, are always implemented and are achieving the desired outcome.

Leadership, openness and transparency

The GP was able to evidence that they had the experience, capacity and capability to run the practice and ensure high quality care. They strove to provide safe, high quality and compassionate care and were visible at all times in the practice. Staff numbers were few and all of them told us that they could discuss matters of concern both with the GP and with all their colleagues. They felt they were listened to and encouraged to speak openly.

We spoke to all of the staff who told us that they attended practice meetings on a weekly basis and we saw minutes from those meetings. They told us there was an open culture and that they had the opportunity, and felt supported, to raise topics for discussion. Each member of staff had been given a personal notebook by the GP and asked to record ideas, suggestions of any risk assessments and examples of good practice in order to indicate a culture of improvement. These had been in place since February 2015 and staff were finding them useful.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. There was a suggestions box at reception and the practice participated in the Friends and Family Test. They had reviewed suggestions received about a water cooler and a smoking area away from the premises and these were provided.

It had gathered feedback from patients through a surveys, comments and complaints and through a virtual patient participation group (vPPG). The vPPG comprised of 17 members of mixed age, ethnicity and gender. Suggestions such as identifying carers and inviting them for well being checks had been agreed and implemented. A request to allow carers to request prescriptions over the telephone had received a response that this could compromise safety and an alternative had been offered directing them to the on-line prescription service. Feedback from the patient survey had revealed low usage of the website and online services. The staff were promoting the service as a more convenient way to get an appointment or to order repeat prescriptions on line and information and advice were available from reception staff.

The practice had also gathered feedback from staff on a weekly basis at their practice meetings. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

The GP encouraged continuous learning and improvement for all staff employed within the practice and the GP had completed 43 hours of CPD across a range of subjects. They had a core set of objectives over the following six months to increase patient use of online services, formally (rather than opportunistically) undertake over 40s health checks and set up a face-to-face patient participation group.