

# S H Vaghela & Dr V N Patel

## Quality Report

The Old Surgery  
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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

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Old Surgery on 17 January 2017. Overall the practice is rated as good.

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

- Staff used an effective system report and investigate significant events and the working culture encouraged openness and honesty to highlight areas for improvement.
- Risks to patients were assessed and well managed, including through medicines management and safeguarding processes.
- 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.
- There was evidence of multidisciplinary working to meet the complex needs of patients, including vulnerable young people and those who received palliative care.
- Patients provided positive feedback about the caring nature of staff and said they took the time to listen to their concerns. We saw staff treated people with compassion, dignity and respect and involved them in care planning and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had adapted access to patient needs and demand such as by providing daily walk-in appointments.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

# Summary of findings

The areas where the provider should make improvements are:

- Ensure locum staff maintain knowledge of the location of emergency equipment.
- Ensure locum staff have access to clinical governance processes, including meetings and learning from significant events.
- Ensure language translation services are provided that do not compromise the quality of clinical information.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice although there was room for improvement in the consistency of this.
- 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 including in relation to medicines management and action taken as a result of national safety alerts.
- The practice had an up to date health and safety policy for staff advising them of the correct protocol for managing risks identified within the practice.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were significantly better than national averages in six clinical domains and similar to national averages in 15 clinical domains.
- Staff assessed needs and delivered care in line with current evidence based guidance although there was no structured system in place to ensure updates were tracked or applied to practice policies.
- Clinical audits demonstrated quality improvement and better patient outcomes, including the management of long term conditions.
- Staff had the skills, knowledge and experience to deliver effective care and treatment because they had access to on-going clinical training.
- There was evidence of effective appraisals and personal development plans.

# Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs, including those with mental health needs and substance addiction.

## Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients reported 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.
- Emotional support and psychology services were readily available.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the clinical commissioning group and other local organisations to secure improvements to services where these were identified.
- Patients said they found it easy to make an urgent appointment and there was continuity of care, with urgent appointments available the same day.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice provided a number of services for patients including home medicine reviews for housebound patients, liaison services with community teams and referral access to a local gym for health promotion and the reduction of diabetes and obesity risk.

## Are services well-led?

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

Good



# Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had up to date policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients, which it acted on. The practice was proactively trying to establish a patient participation group.
- The practice demonstrated a commitment to the health and wellbeing of its staff and had supported them professionally and personally.

# Summary of findings

## The six population groups and what we found

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

### Older people

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

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice invited all patients over 75 years to attend an annual health check which included a blood test, medicine review and advice regarding diet, nutrients, exercise a discussion of social care needs.
- Staff worked with a multidisciplinary care coordinator to ensure patients received timely specialist care, including when they were housebound, had complex needs or were discharged from hospital.

### People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- A practice nurse contacted patients who attended hospital unexpectedly to support them in managing their condition.
- Performance for diabetes related indicators was similar to or better than the national average. For example the percentage of patients with diabetes in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 88% compared to the CCG average of 73% and the national average of 78%. The percentage of patients in the same period in whom the last measured total cholesterol was 5mmol/l or less was 88% compared with the CCG average of 75% and national average of 80%. 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, a named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

# Summary of findings

## Families, children and young people

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

Good



- There were systems in place to identify and support children living in disadvantaged circumstances. This included those who were at risk such as children and young people who had a high number of emergency hospital attendances.
- Immunisation rates were relatively high for all standard childhood immunisations and the practice audited this to ensure continuity.
- The practice's uptake for the cervical screening programme was 69% which was lower than the CCG average of 79% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered sexual health advice and services, including chlamydia screening.
- Child development clinics were offered at six to eight weeks old.
- We saw positive examples of joint working with midwives and health visitors, including a monthly meeting to discuss the care of children on the child protection register.

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

The practice is rated as good for the care of working-age people (including those recently retired and students).

Good



- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a range of health promotion and screening that reflected the needs of this age group, including electronic prescribing and sexual health.
- The practice offered extended hours to support those could not attend appointments during standard working hours.
- Access had been adapted to meet the needs of people in this population group, including daily walk-in sessions, extended evening appointments and weekend appointments available through a local GP hub.

## People whose circumstances may make them vulnerable

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

Good





# Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, those over 75 years of age living alone and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- 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 who were considered vulnerable were given same day priority appointments, including registered carers.

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was significantly better than the CCG average of 83% and national average of 84%. The practice had exception reported 0% compared to the CCG average of 5% and the national average of 7%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia and drug addiction.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016 and related to feedback collected between July to September 2015 and January to March 2016. The results showed the practice was performing in line with local and national averages. Three hundred and forty nine survey forms were distributed and 93 were returned. This represented 4% of the practice's patient list.

- 94% of patients found it easy to get through to the practice by phone compared to the clinical commissioning group (CCG) average of 70% and the national average of 73%.
- 88% 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 72% and the national average of 76%.

- 78% of patients described the overall experience of this GP practice as good compared to the CCG average of 79% and the national average of 85%.
- 82% of patients said the last GP they saw was good at giving them enough time compared to the CCG average of 80% and the national average of 87%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 47 comment cards, which were all positive about the standard of care received. The general themes were that staff were friendly and caring and took the time to listen and understand patient's concerns. Sixteen patients named individual members of staff for their personal care and attention and 23 patients stated they felt continuity of care was a positive element of being a patient there.

## Areas for improvement

### Action the service **SHOULD** take to improve

- Ensure locum staff maintain knowledge of the location of emergency equipment.
- Ensure locum staff have access to clinical governance processes, including meetings and learning from significant events.
- Ensure language translation services are provided that do not compromise the quality of clinical information.

# S H Vaghela & Dr V N Patel

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a GP specialist adviser.

## Background to S H Vaghela & Dr V N Patel

S H Vaghela and Dr V N Patel is based in The Old Surgery, 572 Green Lanes, London N8 0RP and is part of a network of five surgeries that share the same practice manager and are registered separately. The practice has limited parking in front of the building and wheelchair access to the waiting room and clinical areas.

The Old Surgery is one of a number of GP practices commissioned by Haringey Clinical Commissioning Group (CCG). It has a practice list of 2183 registered patients. Haringey is in the third most deprived decile out of 10 on the national deprivation scale. The practice has a higher percentage of unemployed patients (11%) compared to the local average of 10% and national average of 5%.

The clinical team has three GP partners, a practice nurse and two healthcare assistants. Two of the GPs are female and one GP is male. The clinical team provides 12 sessions per week. The non-clinical team includes a practice manager and a team of reception and administration staff.

Appointments are available during the following hours:

Monday – 8.30am to 1.50pm and 4pm to 6pm

Tuesday – 8.30am to 1.50pm and 4pm to 6pm

Wednesday – 8.30am to 1.50pm and 4pm to 7.30pm

Thursday – 8.30am to 1.50pm

Friday – 8.30am to 1.50pm and 4pm to 6pm

Saturday – 9am to 1pm (one day per month)

A local GP hub provides appointments on Wednesdays from 6.30pm to 8.30pm and on Saturdays from 8am to 1pm. Out of these hours, cover is provided by the NHS 111 service.

We had not previously carried out an inspection at this practice.

## 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 16 January 2017.

During our visit we:

- Spoke with a range of staff including GPs, practice nurse, practice manager and administration team.
- Observed how patients were cared for.

# Detailed findings

- Reviewed an anonymised sample of the personal care and treatment records of patients.
- Reviewed clinical audits and the investigations of significant events and complaints.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

# Are services safe?

## Our findings

### Safe track record and learning

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

- Staff submitted incident reports using an electronic system and the practice manager and GP partners maintained oversight of this. In addition staff could escalate incidents directly to the partners for immediate support and action. The lead partner was responsible for investigating clinical concerns and the practice manager was responsible for non-clinical incidents. 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.
- The practice reported 10 significant events in the 12 months prior to our inspection and staff demonstrated learning and changes to practice as a result of significant events. For example, following the inappropriate discharge of a patient with mental health needs from a hospital emergency department to the practice, GPs and the practice manager worked with the local mental health liaison team to ensure patients with complex needs were more appropriately cared for by the multidisciplinary team. Another incident involved the failure of the phone system, which demonstrated the back-up mobile phone system worked well to ensure there was no interruption to the service. Staff demonstrated proactive learning from incidents in other practices, such as ensuring expired consumables were disposed of promptly, even if they were stored securely.
- Incident reporting was underpinned by a being open policy and a blame free culture policy, both of which guided and supported staff to report any mistakes, errors or incidents in the knowledge they would be considered as learning opportunities.

We reviewed safety records, incident reports, patient safety alerts and minutes of the monthly team meetings where

these were discussed. We saw evidence that action was taken as a result of national patient safety alerts, such as the introduction of a more detailed policy to assess the clinical urgency of a home visit.

### Overview of safety systems and processes

The practice had clearly defined and embedded safeguarding systems, processes and practices in place to keep patients safe:

- 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 and each individual could demonstrate how they accessed them. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was evidence staff worked with other agencies to safeguard young people. For example, a GP attended a school conference and liaised with the education authority to support a young person with safeguarding needs.
- GPs met with a health visitor monthly to review each patient on the child protection register and to coordinate support for young pregnant patients.
- One of the partners was the lead for safeguarding children and adults. GPs attended safeguarding meetings and 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. All staff were trained to adult and child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All members of 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 policy outlined the requirement to record in patients' notes if a chaperone had been offered and when a chaperone was used.
- 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 lead who liaised with the local infection

## Are services safe?

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. A healthcare assistant was the lead for the control of substances hazardous to health (COSHH) regulation and ensured chemicals were stored and used in line with national requirements.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe. This included in obtaining, prescribing, recording, handling, storing, security and disposal. Processes were in place for handling repeat prescriptions, which included the review of high risk medicines. The practice carried out regular medicines audits with the support of the local CCG pharmacy teams to ensure prescribing was in line with best practice guidelines.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. A PGD is a written instruction for the supply and/or administration of a named licensed medicine for a defined clinical condition. Their use allows a registered health care professional to administer medicines to a group of patients who fit the criteria without them necessarily seeing a prescriber.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body.

### 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 in place and all staff were aware of their different responsibilities. The practice had up to date fire risk assessments and carried out regular fire drills with the building manager. 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, infection control and Legionella. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.

- The practice provided health and safety guidance for all staff members that included first aid, waste handling, fire procedures and dealing with violent and aggressive behaviour. From looking at incident reports we saw this policy was enforced and patients who behaved violently were removed from the practice list.
- A healthcare assistant had trained as the practice fire marshal and completed practical fire extinguisher training.
- 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 to ensure the main surgery and branch practice always had enough staff.
- Staff used a daily practice report to document daily safety checks, including of the premises and equipment.

### Arrangements to deal with emergencies and major incidents

The practice had 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 an emergency.
- All staff received annual basic life support training and emergency medicines were available.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. We saw evidence that these were regularly checked to ensure all equipment was available, in date and fit for purpose. A first aid kit and accident book were available. The practice did not have signs in place to direct staff to all of the emergency equipment and the locum practice nurse on the day of our inspection was not aware of the location of the defibrillator or oxygen.
- 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 stored securely.
- The practice had an up to date comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and external

## Are services safe?

service contractors. Every member of staff was given a copy of the plan and this was also accessible off site in

case the building became inaccessible. An arrangement was in place with other nearby GP practices to ensure patients had access to healthcare services in the event the surgery suspended its operation.

- All staff had up to date fire and evacuation training.

# 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. National patient safety alerts were received by the practice manager who cascaded them to the relevant team members. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Staff based patient needs assessment on national guidance for the management of long term conditions. For example, the practice scheduled reviews of patients with diabetes or prediabetes in advance to ensure they were delivered at the recommended intervals.

### 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 93% of the total number of points available. Overall exception reporting was 5%, which was similar to the CCG and national averages of 6%. 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.

Exception reporting was significantly lower than the CCG and national averages in the cancer, dementia, mental health, osteoporosis, rheumatoid arthritis and primary prevention of cardiovascular disease clinical domains. For example, exception reporting for cancer was 0% compared to the CCG average of 20% and the national average of 25%. Exception reporting for the primary prevention of cardiovascular disease was 0% compared with the CCG average of 24% and the national average of 31%. Exception

reporting for depression was 33%, which was higher than the CCG average of 21% and national average of 22%. In all other clinical domains exception reporting was similar to local and national averages.

The practice explored contributing factors to exception rates for depression and chronic obstructive pulmonary disease (COPD) to identify areas for improvement in practice. For example, staff identified an error in the electronic coding of patients diagnosed with depression and had implemented changes to improve accuracy. To improve engagement with patients with COPD, the practice proactively offered smoking cessation and spirometry at home to affected patients.

This practice was not an outlier for any QOF or other national clinical targets. Data from 01 April 2015 to 31 March 2016 showed:

- Performance for diabetes related indicators was similar to or better than the national average. For example the percentage of patients with diabetes in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less (01/04/2015 to 31/03/2016) was 88% compared to the CCG average of 73% and the national average of 78%. The percentage of patients in the same period in whom the last measured total cholesterol was 5mmol/l or less was 88% compared with the CCG average of 75% and national average of 80%. Longer appointments and home visits were available when needed.
- Performance for mental health related indicators was similar to or better than the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 85% compared to the CCG average of 84% and national average of 89%. The practice exception reported fewer patients (0%) than the CCG average (5%) and national average (13%).

The partners, practice nurse and practice manager held regular QOF meetings to review the current practice performance, identify areas for improvement and develop an action plan for continued improvement.

There was evidence of quality improvement including from clinical audit:



# Are services effective?

## (for example, treatment is effective)

- There had been four clinical audits completed in the 12 months prior to our inspection, all of which were completed audits where improvements were implemented and monitored. For example, an audit of child immunisations resulted in changes to engagement that increased uptake by 5% in children under the age of two and improved communication with parents from outside of the UK.
- The practice participated in local audits and benchmarking, including prescribing, to compare trends against local and national practices.
- The practice audited cancer referrals to ensure they were timely and appropriate. The audit considered the referrals of each individual GP to identify areas of good practice and learning.

A clinical member of staff called each patient who had experienced an unplanned hospital admission to discuss their condition and review their needs. A GP offered a review appointment within 48 hours of discharge from a planned hospital admission if further care was needed.

### 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. The programme had been tailored to the various roles within the practice such as administration staff and locum GPs. 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, all staff had weekly protected learning time.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training that 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, discussion at practice meetings and engagement with peers at neighbouring practices.
- Staff had access to 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 and the staff we spoke with said they felt appraisals were an effective way to identify their progress and support development needs.
- 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.

- The practice team held weekly teleconference multidisciplinary meetings with health professionals at a nearby NHS acute trust to coordinate the care of patients with complex needs. This involved specialists including psychologists, geriatricians, social workers, physiotherapists and occupational therapists. A summary of each meeting was produced for each professional involved and the practice ensured patient notes were updated.
- Staff used a referral system in line with NICE guidelines to ensure patients with suspected cancer were seen within the national two week wait target.
- Palliative care was provided by a lead GP who coordinated with the multidisciplinary team including the pain team, district nurses, speech and language therapists and a local hospice.
- Where patients were seen out of hours by a GP in the local hub, the practice received an electronic copy of the consultation notes and a GP ensured these were reviewed on the first day the practice was open after the appointment.
- GPs worked with community teams to provide multidisciplinary care plans. We saw examples of these, including where a GP had attended a home visit with other health professionals to establish a care pathway.
- Patients who received palliative care, those living with dementia and other complex needs had individualised care plans that were reviewed regularly. This included where patients had a do not resuscitate authorisation in place.

# Are services effective?

## (for example, treatment is effective)

- We saw evidence that the practice responded to correspondence such as test results on the same day and had an effective system to ensure the information was cascaded to the correct staff and recorded appropriately.
- The practice had a system in place to ensure two-week wait cancer referrals were received by the relevant service.
- The practice shared relevant information with other services in a timely way such as when referring patients to other services.

Staff worked 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. Integrated care management 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.

Staff worked with hospice nurses, social workers and district nurses to provide a coordinated care plan for patients who received palliative care.

### Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance including the Gillick competencies and Fraser guidelines. We also saw evidence staff encouraged young people to talk to their parents or relatives about treatment to ensure they had support.
- 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.

### Supporting patients to live healthier lives

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

- Patients were signposted to relevant services to meet their needs, such as to a smoking cessation advisor. Staff also provided signposting and referral for those at risk of developing a long-term condition and those requiring advice on their diet, drugs and alcohol cessation, patients over 75 years of age, and patients with no fixed abode.
- The practice flagged the computer records of patients who required additional support when attending the practice. This alerted staff to the specific individual needs of these patients when they presented at the reception counter.
- Staff recognised increasing rates of obesity and diabetes in the local population and implemented health promotion strategies to address their needs. This included exercise referrals to a gym with feedback between clinical staff and fitness staff at the gym to monitor progress.
- The practice maintained a register of patients living with HIV and had written to each patient to ask for consent to be included in the results of their regular blood tests to allow the practice to be more involved in their long-term health planning.
- A GP trained in sexual health in primary care settings provided sex education advice to young people, including for family planning and contraception. Specialist sexual health services were provided locally and staff proactively signposted young people to them.

The practice's uptake for the cervical screening programme was 69% which was lower than the CCG average of 79% and the national average of 81%. 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 they ensured a female sample taker was available. 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. Staff also contacted women who did not respond to appointment letters or who did not attend for a booked appointment. The practice audited this process in December 2016 and identified a 38% increase in smear tests from the previous year.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice uptake for bowel cancer screening

# Are services effective?

(for example, treatment is effective)

in the last 30 months was 38% compared to the CCG average of 48% and national average of 58%. The practice uptake for breast screening for patients aged 50-70 in the last 36 months was 57% compared to the CCG average of 64% and national average of 72%.

Childhood immunisation rates for the vaccinations given were above standard compared to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 100% in comparison to the national expected coverage of 90%. The practice scored 9.7 out of 10 in the

NHS England monitoring programme. Average MMR immunisation rates for both doses was at 79% compared to the CCG average of 86% and the national average of 91%.

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.

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and 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 and 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.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 47 comment cards, which were all positive about the standard of care received. The general themes were that staff were friendly and caring and took the time to listen and understand patient's concerns. Sixteen patients named individual members of staff for their personal care and attention and 23 patients stated they felt continuity of care was a positive element of being a patient there.

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

- 84% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 84% and the national average of 89%.
- 82% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.
- 91% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 88% and the national average of 92%.
- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 85%.
- 91% of patients said the last nurse they spoke to was good at giving them enough time compared to the CCG average of 84% and the national average of 92%.

- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and the national average of 87%.

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

Patient feedback from the comment cards we received indicated people felt involved in decision making about their care. 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:

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 82%.
- 84% 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:

- Information leaflets were available in easy read format on request.
- We saw staff discussed do not resuscitate assessments and authorisations with patients and with relatives where appropriate. This included providing information on the process and working with other health providers to ensure this was followed.

### Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available and GPs referred patients to an improving access to psychological therapies (IAPT) team.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 10 of its patients as carers, which represented 0.5% of the practice list. Carers

## Are services caring?

were provided with emotional and mental health support and referrals to social services and respite services. The practice could also refer patients to a dementia day care centre to provide carers with time away from their responsibilities. Staff also signposted carers to a twice-weekly drop-in service in the local community.

The lead GP for palliative care offered patients and their families home visits on demand.

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

# 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 clinical commissioning group (CCG) to secure improvements to services.
- Staff were proactive in adapting services to meet individual needs. For example, a healthcare assistant arranged to make a daily phone call to a carer who was anxious about palliative care to discuss the patient's condition and provide support.
- Staff noted on the booking system if a patient had a hearing impairment and booked a sign language interpreter in advance.
- The practice provided information relevant to the needs of the local population, such as printed guidance on diabetes management in different languages and information on chronic obstructive pulmonary disease in Punjabi and Turkish. The practice also provided information for young people on the Fraser guidelines and what these meant for their care.
- The practice staff spoke seven different languages and could support patients and relatives with interpretation as a result. During our inspection we observed reception staff and healthcare assistants offered an individualised service to patients who were confused about referral letters or other correspondence because of a language barrier. However, there was no formal process for providing interpreting services for patients. This meant staff sometimes relied on internet-based translation software or relatives to translate for them. This presented a risk that information would be incorrectly interpreted.
- There were longer appointments available for patients with a learning disability and patients could request a home visit for their annual review. GPs liaised with consultant psychologists as part of their holistic approach to care, which included an understanding that patients could find it difficult to express their needs.
- The practice provided care to patients with mental health needs according to shared care guidelines. This included medicine reviews.
- The practice followed national dementia friendly guidance from the Alzheimer's Society, including through staff training and regular health checks.

- Same day appointments were available for children, vulnerable patients and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS.

### Access to the service

The practice had established access times and options based on the needs of patients. Appointment slots between 8.30am and 10am Monday to Friday were for walk-in appointments only and pre-bookable slots from 10am were available up to four weeks in advance. Patients for the walk-in session were seen in the order of severity of their condition and patients under the age of five and those who were elderly were prioritised. A monthly Saturday nurse-led clinic was available in the practice.

Patients had access to GPs and nurses every evening, weekend and bank holiday through a local GP hub collaborative. Staff operating this service had full electronic access to patient records and test results to ensure a seamless service was provided.

Outside of these hours, cover was provided by the local cooperative GP service or by referral to the NHS 111 service.

People commented they were able to get appointments when they needed them. We saw evidence that urgent, nurse and phlebotomy appointments were available the same day and routine GP appointments were bookable up to four weeks in advance.

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.

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 73% national average of 76%.
- 94% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% and national average of 73%.

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.

The practice designated a duty doctor each day to take responsibility for home visit requests and emergency appointments. The patient would be contacted by telephone to assess the risk. In cases where the urgency of

# Are services responsive to people's needs?

(for example, to feedback?)

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.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system including a leaflet

which was available in different formats for patient who needed additional assistance. The leaflet advised patients of alternative organisations to raise concerns if they were unhappy with the outcome of the complaint. These included the Parliamentary and Health Service Ombudsman, Healthwatch and the Independent Health Complaints Advocacy.

We saw complaints were reviewed and evidence of actions taken as a result to improve the quality of care. For example, when a patient complained that the GP's advice and referral differed from that made by a private GP they had approached for a second opinion, the GP discussed care pathways and treatment options with them to help them understand why professionals recommended different action.



# 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 and staff knew and understood the values and demonstrated these when providing care and services.
- The practice had a five year action plan to address the need for larger premises and team development.

### 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. The practice was actively upskilling staff to ensure there was adequate cover in each role within the practice.
- The practice manager, an administrator or senior receptionist provided a daily practice report that enabled staff to assess pressure on the service and respond to challenges in the clinical operation. This monitored the number of referrals that were pending, the numbers of patients seen by the GP and nurse and how many patients could not get an appointment on the day.
- The surgery was part of a network of five practices, which the practice manager and GPs covered proportionately. A weekly teleconference was held between all five practices to discuss site-specific issues as well as review patients known to staff wherever they were based on the day of the meeting.
- Although clinical governance for the permanent team was consistent and ensured the safe running of the practice, this system did not always ensure locum or other sessional staff were included. For example, on the day of our inspection a locum practice nurse who was covering a period of absence in the permanent staff said they were unaware of any meetings where significant events, clinical governance or daily reports were discussed.
- Practice specific policies were implemented and were available to all staff, including locum staff.

- A comprehensive understanding of the performance of the practice was maintained. The practice had achieved a high score for QOF points, however the number the exception reporting level was higher than the CCG and national average.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. For example, in October 2016 the practice identified room for improvement in how meetings were documented. As a result a new IT system was used to record meeting minutes and track the completion of actions as a result.
- There were effective 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 demonstrated how they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable, created an inclusive culture and always took the time to listen.

The practice invested in its staff and provided additional support where required to enable them to achieve individual goals.

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.

There was a clear leadership structure in place and staff felt supported by the senior team.

- The whole practice team met daily at lunchtime to discuss any issues, incidents and planning for the rest of the day.



# Are services well-led?

Good 

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

- Practice meetings were held quarterly and each individual had the opportunity contribute to the agenda in advance.
- 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. All staff were involved in discussions about how to run and develop the practice and the partners encouraged staff to identify opportunities to improve the service delivered by the practice. We saw evidence that the practice was cross training staff members to ensure there is greater flexibility to cover various duties during staff absence.
- The practice gathered feedback from patients through a practice survey on an annual basis and reviewed comments from patients on public websites. Changes made as a result of feedback included offering daily walk-in appointments.
- The practice had gathered feedback from staff through quarterly team meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run and felt the five year action plan was achievable.

## 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 and design of the service.

- The practice did not have a current patient participation group (PPG) and had contacted 250 patients to gauge interest in forming a new group. Posters in the waiting room and a notice on the practice website also advertised this to try and attract interest.

## Continuous improvement

The practice team identified the need for future sustainability planning to consider how to expand the premises, transition into a training practice and expand services to meet local needs and work with other nearby surgeries. To work towards this the practice manager was working with the team to increase their training, competencies and career development plans. For example, a receptionist was being supported to train as a healthcare assistant and an existing healthcare assistant had joined a local mental health project to develop a hospital admission avoidance programme for at-risk patients.