The Elms Practice

Quality Report

Hayling Island Health Centre
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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 Elms Practice on 2nd July 2015. Overall the practice is rated as good. Specifically the practice is rated as good for providing safe, effective, caring, responsive and well-led services. The practice is also rated as good for providing services to the population groups of 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 and people experiencing poor mental health, including people with dementia.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Incidents were reviewed and learning from incidents was shared with practice staff.
- The practice used proactive methods to improve patients' outcomes and maximise efficiency. For example, if patients needed more than one review these were completed at the same appointment.
- Patients said they were treated with compassion and dignity and that they were involved in decisions about their care.
- The practice made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- The practice had achieved 99.6% of the total quality points available and this was higher than the national average of 94.2%.

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

In addition the provider should:

- Ensure that airway tubes are in date.
- Review the policy for the retention of receipts for faxed referrals.
- Produce a vision, strategy and business plan.

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 their responsibilities to raise concerns and to report incidents. Lessons were learned and promulgated to support improvements. There were effective systems in place to safeguard patients and to manage risks to patients and staff. However we found that one piece of equipment had passed it's expiry date.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that patients' outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence. Staff had lead roles, worked in multi-disciplinary teams and were provided with additional training and support to enhance their skills and improve patient outcomes. For example, the lead nurse for asthma had completed a diploma in asthma and was supported by a respiratory specialist. The practice participated in the Quality and Outcomes Framework (QOF). Data for the period 1 April 2013 to 31 March 2014 indicated that the practice had achieved 99.6% of the total QOF points available and this was higher than the national average of 94.2%.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the National GP Survey indicated that patients rated the practice higher than others for some aspects of care. Patient comments indicated that they felt they were treated with dignity, respect and compassion. The practice provided information to patients about their conditions and involved them in decisions about their care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its population and worked with the Clinical Commissioning Group and other service providers to meet patients' needs. The national GP survey rated the practice higher than others for ability to access appointments and all patients were allocated to a named GP to provide continuity of care. The practice had acted on information received from patients and information received through the patient participation group in order to improve the service. Information about how to complain was available to patients and learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for providing well-led services. Staff were clear about their roles and responsibilities and there was a clear leadership structure and staff felt supported by management. The practice had policies and procedures in place to govern activity and regular meetings were held, which included members of staff from all departments. Staff had regular appraisals and reviews and were supported to attend training. The practice did not have a clear documented vision and strategy but the vision and strategy were discussed at practice meetings.

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. Approximately 50% of the practice population were over the age of 65. Nationally reported data showed that outcomes were good for conditions commonly found in older people. The practice provided proactive care to older people, care homes and nursing homes were visited by practice nurses in order to carry out annual reviews and vaccinations. The practice provided care homes with an additional contact number so that they could contact the practice quickly in order to obtain advice and treatment for residents.

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 outcomes for patients with long-term conditions such as diabetes were higher than the national average. Patients were registered with a named GP. The practice had a register of patients with long term conditions and patients who could not attend the practice would be seen in their own homes by a practice nurse to review their condition. For those patients with complex long term conditions GPs worked with other healthcare professionals to review their care and multi-disciplinary team meetings were held at the practice.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice identified children who were living in vulnerable circumstances. Quarterly meetings were held with health visitors to review the care provided to vulnerable children. The practice offered an enhanced service for childhood immunisations and immunisation rates for children were in line with national averages. Appointments were available outside of school hours and consulting rooms were on the ground floor making them accessible to families with pushchairs.

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 practice offered health checks to people over the age of 40 and offered extended appointments until 8pm on Tuesday and alternate Wednesdays.

Summary of findings

The practice offered on line services such as appointment booking and repeat prescriptions. The practice had put systems in place so that patients could check information about test results, allergies and basic care planning on line.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. They had a register to identify patients who were vulnerable and computer alerts were added to patients' records to alert staff that a patient was vulnerable. The practice carried out annual health checks for patients with learning disabilities and patients who could not attend the practice were reviewed at home by the practice nurse. The practice offered longer appointments for patients with learning disabilities and patients who did not attend for appointments were contacted by telephone. The practice identified and followed up on patients who had not collected repeat prescriptions. The practice worked with multi-disciplinary teams to provide care to vulnerable patients and meetings were held with health visitors to discuss care for children at risk.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health including patients with dementia. Data indicated that 86.07% of patients with dementia had received a face to face care review in the last 12 months compared to the national average of 83.82%. The practice signposted patients experiencing poor mental health to local support groups and patients experiencing poor mental health are given longer appointments in order to review their care.

Summary of findings

What people who use the service say

The national GP patient survey results published on 8 January 2015 showed that the practice was performing in line with local and national averages. There were 123 responses to the survey. 49% of people issued with a survey responded.

- 79% of respondents found it easy to get through to this practice by phone compared with the CCG average of 84% and the National average of 74%.
- 82% of respondents found the receptionists at this practice helpful compared with the CCG average of 90% and the National average of 87%.
- 86% of respondents with a preferred GP usually got to see or speak to that GP compared with the CCG average of 72% and the National average of 60%.
- 84% of respondents were able to get an appointment to see or speak to someone last time they tried compared to the CCG average of 89% and the National average of 85%.
- 91% of respondents said that the last appointment they got was convenient compared to the CCG average of 94% and the National average of 92%.
- 82% of respondents described their experience of making an appointment as good compared to the CCG average of 80% and the National average of 74%.
- 74% of respondents indicated that they usually wait 15 minutes or less after their appointment time to be seen compared to the CCG average of 61% and the National average of 65%.
- 70% of respondents felt that they didn't normally have to wait too long to be seen compared to the CCG average of 58% and the National average of 58%.

The last report from the Patient Participation Group (PPG) dated 30 March 2015 indicated that the group had seven patients who attended meetings and 136 virtual PPG members. The group had identified three priorities for actions which included reducing waiting times for appointments with GPs and nurses, providing better on line access to information for patients and improving the service provided by reception staff. The report indicated that action had been taken to address each of the issues raised.

We reviewed information from the Friends and Family test dated 30 March 2015. 97% of the 417 respondents indicated that they would be either extremely likely or likely to recommend the practice to their friends and family.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comments cards and patients commented positively about the service they received. Patients indicated that the staff were professional and caring and that they were treated with dignity and respect. Two patients commented that they sometimes had to wait for routine appointments. We talked to two patients and two members of the PPG. Patients told us they were happy with the service provided, but one patient indicated that it was sometimes difficult to get an appointment. A patient told us they were not aware of how to contact the out of hour's service. Representatives from the PPG said that the practice and the PPG were very responsive, and members attended locality group meetings. The PPG were instigating a project to reduce social isolation for patients.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that airway tubes are in date.
- Review the policy for the retention of receipts for faxed referrals.
- Produce a vision, strategy and business plan.

The Elms Practice

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 specialist advisor and practice manager specialist advisor.

Background to The Elms Practice

The Elms Practice is located at Hayling Island Health Centre, Elm Grove, Mengham, Hayling Island, Hampshire, PO11 9AP. The building is managed by NHS property services and is shared with another GP surgery, Hayling Island Voluntary Services, Podiatry Services and a phlebotomy service. The practice has four consulting rooms and four treatment rooms.

The practice provides care to 9120 patients. Staff include four GP partners, one GP specialist and two GP registrars (four female GPs and three male GPs), five practice nurses, a practice manager, reception and administration staff. The practice is a teaching practice and also trains student doctors in conjunction with Southampton University. There were no trainee doctors at the practice at the time of our visit. The practice has a General Medical Services contract (a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract).

Approximately 50% of the patient population are over the age of 65 and the practice provides care to residents in 11 care and nursing homes, seven care homes for patients with learning disabilities and three care homes for children. The practice provides care and treatment to a high number of temporary residents during the holiday season.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8.20am to 12.10pm and 15.20pm and 6pm on weekdays. Extended hours surgeries are offered until 8pm on Tuesdays and alternate Wednesdays.

The practice has opted out of providing out-of-hours services to their own patients. Patients can obtain out of hours care using the 111 service and care is provided by Hampshire Doctors on call.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

How we carried out this inspection

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 2 July 2015. During our visit we spoke with a range of staff, including GPs, nurses, practice manager, administration and reception staff and spoke with patients who used the service. We observed how people were being cared for and reviewed documentation such as policies and procedures. We 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?

Detailed findings

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

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

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

Good

Are services safe?

Our findings

Learning and improvement from safety incidents

The practice had effective systems in place for reporting, recording and monitoring significant events. People affected by significant events received apologies and were told about actions taken to improve care. We reviewed records for ten significant events that had occurred during the last 12 months. GPs had partners meetings every Monday and significant events were discussed at these meetings. Learning from significant events was discussed with nurses, reception and administration staff. We looked at an event and an action was required that involved writing to all care homes in the area to clarify procedures around Deprivation of Liberty Safeguarding and we saw that this action had been taken.

The practice received safety information from a number of other organisations. National Patient Safety Alerts were received through the Central Alerting System. Staff told us that this information was distributed to them but the distribution was not recorded and there was no record of actions taken as a result of alerts received.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse. There was a safeguarding policy and a whistleblowing policy in place. There was a named GP who was the safeguarding lead. The safeguarding lead was trained to level 3 in Child Protection and other GPs were trained to either level 2 or level 3. Other staff had received training that was appropriate to their role and all staff had received training in safeguarding vulnerable adults. GPs attended multi-disciplinary safeguarding meetings and safeguarding information was discussed at weekly partners' meetings. Staff understood their responsibilities with regard to safeguarding and were able to identify when they would report any concerns to the named lead.
- A chaperone policy was in place and there were notices advising patients that they could request a chaperone (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). A patient told us that they had been offered a chaperone during their procedure. Only clinical staff acted as chaperones and staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for managing risks to patients and staff. The practice had a Health and Safety Policy and risk assessments were in place. The building was shared with another GP practice and the fire risk assessment was completed by NHS property services. Fire equipment had been checked and was tested in November 2014. Electrical equipment had been checked to ensure that the equipment was safe to use and portable appliance testing had been carried out on equipment in February 2015.
- The practice had policies and procedures in place for the management of infection control and there was a named infection control lead. We observed the premises to be clean and tidy. Staff had received training in infection control and an infection control audit had been completed by an external organisation on 13 May 2015. The report had not been received but staff were able to discuss the actions they had taken since the audit. A further audit had been completed on 29 June 2015. There were procedures in place for the management of legionella (Legionella is a term for particular bacteria which can contaminate water systems in buildings). Legionella checks were completed on a quarterly basis and staff had a system in place to run taps twice weekly in those rooms, that were not frequently used, to prevent the build up of bacteria.
- The practice had arrangements in place for the management of medicines. The practice had a named prescribing lead, who sits on the Clinical Commissioning Group Prescribing Committee and works with the community pharmacist to review systems and processes. The practice had robust systems for the management of prescriptions and the recall of patients for medicines reviews. Blank prescriptions were stored securely and there were systems in place to monitor their distribution. Prescribing audits were completed, however, prescribing indicators identified that the number of Ibuprofen and Naproxen Items prescribed as a proportion of all Non-Steroidal Anti-Inflammatory drug items prescribed was significantly lower than the

national average. Between the period of 1 January 2014 and 31 December 2014 the prescribing rate was 59.29% compared to the national average of 75.13% and this had not been audited by the practice.

- Nurses completed vaccinations under Patient Group Directions (PGDs) that were signed and appropriate for use (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Vaccinations were stored in fridges and fridge temperatures were monitored. Stocks of vaccinations that we reviewed were in date for use. Nurses received newsletters providing information on public health and immunisations from public health organisations.
- There was recruitment policy in place that had been reviewed in June 2015 and a staff handbook was available. We reviewed recruitment records for three staff and found that appropriate recruitment checks had been completed, for example, proof of identification, references, qualifications, registration with the appropriate professional body and appropriate DBS checks.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Business continuity arrangements, included arrangements for managing unplanned staff absences. For example, the practice had used a locum GP when additional appointments were required and the practice had liaised with a local college to provide an apprenticeship in administration.

Arrangements to deal with emergencies and major incidents

The practice had a button that could be pressed to alert staff if there was an emergency and the practice computer system had an instant messaging system that could also be used to inform staff in consultation rooms that an incident had occurred. Staff had received training in the management of medical emergencies and emergency equipment and medicines, including the use of a defibrillator (a device that gives the heart an electric shock when it has stopped) were available. Portable oxygen cylinders were checked weekly and adults' and children's oxygen masks were available. Emergency medicines were in date and fit for use but we found that a piece of equipment for managing the patient airway had passed its expiry date. One nurse was the area coordinator for first responders.

The practice had a comprehensive business continuity plan in place for major incidents. The plan included what to do in an unplanned event such as power failure or staff sickness and included emergency contact information 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 relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff told us they also used guidance from the Faculty of Sexual Health. Links to guidance were available on the practice computer system but there was no formal route for recording the distribution of updated guidance to staff. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. The practice manager explained how the practice reviewed NICE guidance and ensured that policies and procedures were updated to reflect current guidance.

All patients had a named GP and each care home had been allocated to a named GP. GPs told us they led in specialist clinical areas and nurses had lead roles in conditions such as chronic obstructive pulmonary disease (the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease), asthma, immunisations and diabetes. The practice held registers of patients who were vulnerable, including patients over the age of 75, patients with long term conditions, learning disabilities, dementia and those who were homeless. A computer generated template was used to create care plans for patients that were vulnerable such as those who were frail, elderly or receiving end of life care. Health checks were offered to all new patients and patients over the age of 40.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually). They used information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Data for the period 1 April 2013 to 31 March 2014 indicated that the practice had achieved 99.6% of the total QOF points available and this was higher than the national average of 94.2%.

- Performance for diabetes related indicators were better than the national average in most key areas. For example, the proportion of patients on the diabetes risk register, with a record of foot examination and risk classification within the preceding 12 months was 91.73% compared to the national average of 88.35%.
- The proportion of patients with hypertension for whom the last blood pressure reading measured in the preceding nine months was 150/90mmHg or less was 84.29% compared to the national average of 83.11%.
- Performance for mental health related indicators was higher than the national average. For example, the proportion of patients with schizophrenia, bipolar affective disorder and other psychoses who have had a comprehensive, agreed care plan documented in their record, in the preceding 12 months was 92.16% compared to the national average of 86.04%.
- The proportion of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 86.07% compared to the national average of 83.83%.

QOF data for the period 1 April 2014 to 31 March 2015 also indicated that the practice performance had been maintained, achieving a total of 99.05% of the maximum points available. We were told that the practice employed a consultant who visited the practice three times each year to review data and look for outliers in QOF clinical targets. The practice had implemented systems to maximise efficiency and improve outcomes for patients. For example, where patients had more than one condition then all conditions were reviewed at the same appointment and nurses visited care homes to review patients and provide immunisations.

Clinical audits were carried out to demonstrate quality improvement and information was shared with all relevant staff. We reviewed three clinical audits that had been completed in the last 12 months. The practice had used audits to identify areas were improvements could be made and implemented changes as a results of the audits undertaken. For example, the practice had completed an audit of asthma patients on multiple courses of oral steroids. Two cycles of the audit had been completed and this had led to improved record keeping and improved procedures for reviewing patients with asthma.

Effective staffing

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

Good

Are services effective?

(for example, treatment is effective)

- The practice had a training policy which had been reviewed in June 2015 and this included procedures for induction training and continuation training. The induction programme covered key areas such as Health and Safety and patient confidentiality.
- Staff training needs were identified through a system of appraisals, training needs analysis, meetings and reviews. Staff told us they were supported to undertake additional training that was relevant to their role. For example, a nurse had completed a diploma in asthma care, attended respiratory group meetings, was provided with additional support from an asthma specialist and had the provision of smoking cessation training agreed by the practice. Two members of staff told us the practice had funded their qualifications with the Institute of Leadership and Management. We were told that the practice was a good learning environment and GPs would discuss interesting cases with nurses in order to promote learning. The practice was accredited as a training practice in 2013 and had two GP registrars who were not present during our inspection (a GP registrar is a qualified doctor training to become a GP through a period of working and training in a practice).
- The practice held meetings to share information and promote learning. GP partners' meetings were held weekly. Meetings were held every month with GPs and nurses but these meetings were not minuted. Reception training meetings were held on a monthly basis. We reviewed minutes of meetings dated 24 September 2014 and 28 October 2014. We saw that prior to the meetings staff were invited to add items to the agenda or to provide information in a sealed envelope if they did not wish to be identified. Meetings were held between GPs and administration staff every two months and we reviewed minutes for the meeting dated 25 February 2015. We saw a memo where actions from another meeting had been disseminated to those who were not present.

Coordinating patient care and information sharing

The practice had an information management and technology direct enhanced service. The practice had an information Governance Policy and Subject Access Request Policy, which had been reviewed in March 2015. The practice provided a leaflet to patients about how health records were used which documented their rights under the Data Protection Act. A separate leaflet was available entitled guidance for staff, volunteers and contractors handling patient information. All staff had completed annual refresher training in data protection and information sharing. Some policies and procedures had been added to the practice computer system and the practice manager had a plan in place to review and upload all policies and procedures by the end of 2015. The practice was located in a small community, where many of the patients were known to staff and staff were also treated at the practice. Additional procedures had been put in place to safeguard patient records. Audits on access to records were completed to identify any inappropriate access.

Staff used the practice computer system to coordinate information about patient care. This included information about safeguarding, out of hours care, hospital discharges, test results and referrals to hospital. Secretaries each worked for a named GP, the practice used electronic referral, fax or the Choose and Book System to coordinate hospital appointments and patients would be supported during this process. Where patients had been referred urgently under the two week wait, secretaries followed up appointments to ensure that they have been received by the patient. However were a routine referral was made, receipts for faxed letters were retained for three months, even though the patient may have to wait longer than this for their appointment.

The practice had robust systems in place for communicating with other service providers such as the out of hours service. Multi-disciplinary safeguarding meetings were held and staff met with health visitors every three months. Care homes were each allocated a named GP and vulnerable patients had care plans in place. Patients were given a copy of their care plan to sign.

Consent to care and treatment

Patients' consent to care and treatment was sought and staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. The practice had policy and guidance on informed consent dated March 2015, which referred GPs and nurses to the British Medical Association Mental Capacity Act toolkit. When providing care and treatment for children and young people, assessments of capacity to consent were carried out in accordance with relevant guidance and the practice policy provided information about Gillick competence (Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the

Good

Are services effective?

(for example, treatment is effective)

implications of those decisions). Consent to care and treatment was documented in patients' records and specific consent forms were used for some immunisations. A member of staff explained a scenario where a family member, who was not a parent, attended with a child for immunisations, the practice contacted the child's parents and obtained their consent prior to proceeding with treatment.

Health promotion and prevention

Patients requiring additional support were identified using the practice computer system and the practice also had registers of patients who were vulnerable due their circumstances or medical conditions. The practice had a high number of elderly patients and had identified that many of these patients were isolated and required additional support. The patient participation group was in the process of setting up a "men's shed", which would be a support group where men could meet and pursue hobbies in order to reduce social isolation. The practice provided a monthly newsletter and used this as an opportunity to provide health information to patients. The most recent practice newsletter produced in June 2015, provided information and advice about managing health during a heat wave. The Practice Manager or Data Manager wrote a monthly column in the local newspaper to provide information and advice to patients.

The practice provided smoking cessation advice, opportunistic chlamydia screening and advice to patients on managing obesity. There was a register to identify patients whose health was at risk due to obesity. The practice provided health checks to new patients and those patients that were over the age of 40.

The practice had a comprehensive screening programme and patients were actively recalled for health screening. The proportion of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the last five years was 87.99%. This was higher than the national average of 81.88%

Childhood immunisation rates for vaccinations were comparable to national averages. For example, childhood immunisation rates for vaccinations given to under two year olds ranged from 82.4% to 100% and five year olds from 82.6% to 95.7%. Flue vaccination rates were also comparable to national averages:

- The proportion of patients aged over 6 months to under 65 years in the defined influenza clinical risk groups that received the seasonal influenza vaccination was 73.29% compared to the national average of 73.24%.
- The proportion of patients aged 65 and older who have received a seasonal flu vaccination was 57.86% compared to the national average of 52.29%.

The practice provided some information to patients about the Out of Hours service but this was limited. There was a leaflet entitled Choose Well but this did not sign post patients to use the 111 service, however this information was available on the practice website and on the practices Envisage media screen in the main waiting area.

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 patients were treated with dignity and respect. During our inspection an elderly patient attended with a problem that was causing them distress and staff arranged for them to be seen by the nurse immediately in order to resolve the problem even though they did not have an appointment. 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 consultation and that conversations taking place in these rooms could not be overheard. Patients approached the reception desk one at a time so that other patients could not hear their conversations and when chatting to patients we noted that reception staff did not discuss confidential information.

All of the 37 comment cards we received were positive about the service provided and indicated that staff were professional and caring and treated patients with dignity and respect. However two patients commented that they sometimes had to wait for routine appointments. We spoke with two members of the patient participation group (PPG) on the day of our inspection and they told us that the practice listened to patients and tried to help patients, for example, by reducing social isolation.

Results from the national GP survey also indicated that patients were happy with how they were treated and they felt they were treated with compassion and respect. The practice was above average for its satisfaction scores for GPs and in line with national averages for its satisfaction scores for nurses. For example,

- 95% of respondents said that the last GP they saw or spoke to was good at listening to them compared with the CCG average of 90% and the national average of 89%.
- 97% of respondents said that the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 89% and the national average of 87%.
- 98% of respondents said that they had confidence and trust in the last GP they saw or spoke to compared with the CCG average of 97% and the national average of 95%.
- 92% of respondents said that the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 89% of respondents said that the last nurse they saw or spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 90%.
- 82% of respondents said that they found the receptionists at this practice helpful compared to the CCG average of 90% and the national average of 87%.

Where the survey had identified areas for improvement, the practice had taken action to address the concerns raised. For example, the practice had provided a quarterly training session for reception staff using scenarios and discussions about patient care pathways. They had also provided a leaflet to patients about the role of the reception staff and the challenges they face.

Care planning and involvement in decisions about care and treatment

Patients were involved in decision making about the care and treatment they received. Care plans were signed by patients to say that they agreed with their contents. Results from the national GP survey indicated that patients felt involved in the care they received from GPs and nurses and patients were given information to support them to make decisions about their care. For example,

- 89% of respondents said that the last GP they saw or spoke with was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 93% of respondents said that the last GP they saw or spoke with was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 91% of respondents said that the last nurse they saw or spoke with was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.

Good

Are services caring?

- 91% of respondents said that the last nurse they saw or spoke with was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.

The practice had very few patients who did not speak English as a first language but translation services were available. The practice website had a link to a translation page were patients could select the language they wished to use.

Patient/carer support to cope emotionally with care and treatment

Information was available in the waiting room to inform patients how to access a number of support groups and organisations.

The practice computer system alerted staff to patients who were vulnerable and patients who were carers. Information for carers was available on the practice website. Staff told us they provided additional support to patients when required. For example, secretaries supported patients to make hospital appointments using the Choose and Book system.

The practice provided end of life care to patients using the Gold Standards Framework (The Gold Standards Framework is a systematic, evidence based approach to optimising care for all patients approaching the end of life). Staff told us that if patients had suffered bereavement, their usual GP contacted them and visited them to offer their support. They also provided advice on how to find support services if required.

Patients were supported to attend drug and alcohol services and staff signposted homeless patients to organisations that could support them to obtain accommodation.

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 Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients. For example, the practice provided directed enhanced services in childhood vaccinations and immunisations and influenza and pneumococcal immunisations. Nurse led baby immunisations clinics were conducted using two nurses in order safeguard patients. Services were also planned to take into account the needs of different patient groups. For example.

- The practice held a pre-bookable clinic from 6pm to 8pm on a Tuesday evening and alternate Wednesday evenings.
- There were longer appointments available for patients with learning disabilities and patients who were vulnerable.
- GPs and nurses provided home visits to patients who could not attend the practice.
- The practice provided same day appointments for patients who needed to be seen urgently.
- The practice was accessible to patients in wheelchairs and patients with pushchairs and had a hearing loop installed.
- The practice provided information to patients about how to prevent health issues such as information about sun safety and had started to set up a men's shed to prevent loneliness.

The practice had responded to information raised in the Patient Participation Group Enhanced Survey published in March 2015 and had identified and addressed three specific areas for improvement. For example, the practice had improved information available to patients by adding information on immunisations and allergies to the patient on line record and created a pathway so that patients could access part of their medical records on line.

Access to the service

The practice was open between 8am and 6.30pm Monday to Fridays. Appointments were available between 08.20 and 12.10pm and between 3.20pm and 6pm. Extended hours' surgeries were available on Tuesdays and alternate Wednesdays between 6pm and 8pm. Routine appointments were available with a GP within one week and appointments were available the same day for patients requiring urgent appointments. Telephone appointments were available and patients were triaged by telephone to identify whether their need was urgent. Patients who attended the practice could be triaged by nurses. Some vaccination clinics were held on a Saturday to provide additional access to working age patients and families.

Results from the National GP survey indicated that patients satisfaction with how they could access care and treatment was above the national average, For example,

- 78% of respondents said that they were satisfied with the surgery opening hours compared to the CCG average of 77% and the national average of 76%.
- 79% of respondents found it easy to get through to the practice by telephone compared to the CCG average of 84% and the national average of 74%.
- 82% of respondents described their overall experience of making an appointment as good compared to the CCG average of 80% and the national average of 74%.
- 74% of respondents indicated that they usually waited 15 minutes or less after their appointment time to be seen compared to the CCG average of 61% and the national average of 65%.

The practice had responded to concerns raised about waiting times for appointments by using a locum GP one day per week and a locum nurse on a Friday. This had eased waiting times to ensure that patients were not waiting more than three days for an appointment with a nurse and had reduced the waiting times for an appointment with a GP. A member of staff told us that the practice was flexible in its approach to appointments, for example, appointments were offered outside of set vaccination clinics if this was more convenient for the patients.

Listening and learning from concerns and complaints

The practice had systems in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the practice manager was the designated responsible person who handled all complaints in the practice. They provided information to patients who wanted to complain or make suggestions on the practice website and in the practice information booklet.

We looked at four complaints that had been received in the last 12 months and found they had been satisfactorily handled. Complaints were discussed at weekly meetings

Good

Are services responsive to people's needs?

(for example, to feedback?)

with GPs, nurses and administration staff. Meetings were minuted and we found that some of the minutes did not record detailed actions but they were supplemented by a book that was used to record actions that had been taken as a result of learning from complaints. The practice did not have systems in place to record low level complaints in order to identify trends.

The practice obtained feedback from patients and were concerns had been raised the practice had taken action to address these concerns, For example, the practice had provided training to reception staff after complaints that patients were not happy with the service they had received from them. Information about this training was publicised to patients through newsletters so that patients knew what action had been taken and the practice produced a leaflet for patients about the role of reception staff and the challenges they face.

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 did not have a five year business plan or documented vision. We were told that the practice strategy was discussed by GP partners in weekly meetings. The practice had a Statement of Purpose but this indicated that the practice provided the regulated activities of treatment of disease, disorder or injury, diagnostic and screening procedures, surgical procedures, family planning services, antenatal and postnatal care and triage and medical advice provided remotely.

Governance arrangements

The practice had an overarching governance framework which was supported by comprehensive policies and procedures. Policies and procedures were available to all staff in paper copy and the practice manager had a plan in place to ensure that all policies and procedures were available on the practice computer system by the end of 2015.

There was a clear staffing structure and staff were aware of their own roles and responsibilities. Staff were also supported to understand the roles of others in their practice and the practice organised events were staff could work in other areas of the practice to gain a better understanding of each other's roles.

There were systems in place to identify and manage risks and issues. The practice responded to risks and actions raised and had system in place to share learning from significant events and issues raised. However one item of emergency equipment had passed its expiry date for use and this had not been picked up using the provider checks on emergency equipment.

The practice had a system of clinical audit that was used to monitor quality and improve care. An external auditor was also used to monitor data and identify and data outliers that were investigated to identify areas of improvements.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and had each undertaken specific roles in order to help the practice run more effectively. The partners in the practice were visible and staff told us they were well supported by the GPs and were encouraged to provide feedback and to contribute to practice meetings.

Staff had regular meetings, which included whole practice meetings, GP meetings, nurses meetings and meetings for reception and administrative staff. Staff participated in target training days that were provided by the clinical commissioning group and were encouraged to undertake additional training to support their role, for example, a nurse had been supported to undertake a diploma in asthma care and both the practice manager and their deputy had been supported to undertake the level five diploma in leadership and management. Staff told us they felt valued and respected and were encouraged to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and were proactive in obtaining feedback through the patient participation group and through the family and friends test. The practice had responded to information received and had identified the top three areas of concern and had put actions in place to address these issues. The practice had evaluated the actions it had taken to see if they had been successful. For example, the practice had recorded the impact of training for reception staff had resulted in a reduction in complaints about reception staff and happier staff who felt involved in good team work.

The practice gathered feedback from staff through meetings, appraisals and discussion. Staff told us they felt supported to provide feedback and could discuss concerns or issues with colleagues and management. A staff member identified they had been supported to implement change after receiving additional training and had been provided with additional equipment in order to do this.