# The Pembridge Villas surgery

## Quality Report

45 Pembridge Villas
Notting Hill Gate
London
W11 3EP
Tel: 020 7727 2222
Website: www.pembridgevillas-w11.nhs.uk

Date of inspection visit: 21 April 2015
Date of publication: 13/08/2015

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at 'The Pembridge Villas Surgery' on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services to the six population groups we inspect - People whose circumstances may make them vulnerable; Older people; People with long-term conditions; Families, children and young people; Working age people (including those recently retired and students); and People experiencing poor mental health (including dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- There was a good skill mix amongst the GPs with some clinicians having specialised areas of expertise.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and were complimentary about the practice's walk-in service as this accommodated patients who required urgent appointments the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff during practice meetings, appraisals, and away days.

# Summary of findings

- A practice had an active patient participation group (PPG). The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and the PPG.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients who used services were assessed and well managed, such as those relating to infection control, medicines management, and business continuity. Portable equipment had been calibrated and tested for safety. There were enough staff to keep patients safe. Staff who performed chaperone duties had received training and understood their responsibilities when acting as chaperones.

**Are services effective?**

Good

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

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data from the national patient survey 2015, a patient satisfaction survey carried out by the practice, and results from the Friends and Family Test showed that patients rated the practice well for several aspects of care. For example, the practice was rated above the CCG and national averages for patient satisfaction on consultations with the GPs and nurses. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

# Summary of findings

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The majority of patients we spoke with were satisfied with the appointments system, and in particular the availability of the walk-in clinics. Patients confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be with the GP of their choice.

The practice had sought feedback from staff, patients, and the patient participation group, and had acted upon that feedback. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and designated staff led in specific areas such as safeguarding, infection control and complaints. Staff felt management were approachable and supportive. The practice had a number of policies and procedures to govern activity and governance issues were discussed during the monthly practice meeting. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

### Older people

Good

The practice is rated as good for the care of older people. The practice had a lower percentage of patients over the age of 75 (2.4%) when compared to the national average (7.6%). The income deprivation level affecting older people was 21 compared to the national average of 22.5.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Patients aged 85 or over were offered an annual health check, and all patients over the age of 75 had named GP. The practice was responsive to the needs of older people, and offered home visits for those with enhanced needs. Clinical staff had close working relationships with district and palliative care nurses to discuss care planning for patients who required extra support. They also signposted patients who required further advice and care to social care services, and voluntary groups.

### People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The percentage of patients at the practice with a long standing health condition (34.8%) or with health related problems in daily life (34.6) was lower when compared to the national averages (54% and 48.8% respectively).

Nursing staff assisted the GPs in chronic disease management. Patients with long term conditions were invited to a structured annual review to check that their health and medication needs were being met. The practice held clinics for patients with long term conditions such as chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease (CKD) and coronary heart disease (CHD), and followed National Institute for Health and Care Excellence (NICE) guidance around treatment for these groups of patients.

For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Longer appointments and home visits were available when needed.

### Families, children and young people

Good

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

# Summary of findings

The practice had more children aged 0 to 4 (7.5%) than the England average of 6%. There were less children aged 5 to 14 (5.7%) and under 18 (6.7) when compared to the national averages of 11.4% and 14.8% respectively. The income deprivation level affecting children was 19 compared to the national average of 22.5.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, health visitors were attached to the practice and attended multidisciplinary meetings to discuss children at risk. There was a designated nurse who led on child protection, and all staff were aware of their responsibilities for safeguarding children.

Antenatal and postnatal care was offered as part of a shared care programme with the hospital, and a comprehensive information pack was given to women as part of their antenatal care. The practice offered a weekly baby clinic with the GPs and a health visitor, and the nurses provided childhood immunisations. Performance for all standard childhood immunisations was above average for the locality. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice also offered advice on contraception and sexual health, and chlamydia screening was routinely offered to patients aged 16-25 years during their new patient check-up.

**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 had a predominantly young adult population between the ages of 25 and 44. The number of patients in paid work or full-time education was higher than the national average, 69.2% compared to 60.2%.

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. Daily walk-in clinics were available in the morning and afternoon, except on Wednesdays when there was only a morning session. Extended hours were available for booked appointments from 18:30 to 20:00 on Monday, Tuesday, Wednesday and Thursday evenings, and on Wednesday morning from 08:00 to 08:30.

The practice offered online facilities to book appointments and request repeat prescriptions. Telephone consultations were available for patients who found it difficult to access the practice. There was a range of health screening programmes (including

# Summary of findings

cervical and bowel cancer screening), and NHS health checks (for patients aged 40-75) that reflected the needs for this age group. Health promotion advice was offered and health promotion material was available at the practice and on the website.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including housebound patients, carers, and those with a learning disability.

The percentage of patients with a caring responsibility was lower than the national average at 12.8% compared to 18.2%. The practice's computer system alerted GPs if a patient was a carer, and carers were offered health checks, the flu vaccination, and referred to various support services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. We were told that the practice also supported patients from a local women's shelter that were fleeing domestic violence. 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.

The practice looked after patients with learning disabilities from a local care home. There was a named GP for these patients, and patients were also given the choice to see any GP at the practice. Longer appointments and an annual health checks were offered to patients with a learning disability.

The practice recognised the needs of homeless patients by offering them an extended registration health check which included screening for mental health problems, drug and alcohol issues, and infectious diseases. The practice also looked after 25 patients who were previously homeless but were now living in supported housing. These patients were allowed to register with the practice despite their supported housing being located outside of the geographical boundaries for the practice. The GPs had a good knowledge of the health challenges experienced by homeless patients, and three GPs had further experience of working in another practice which provided healthcare services specifically for homeless people.

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

Good

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

# Summary of findings

Annual physical checks and mental health reviews were offered to patients on the mental health register, and data from the quality and outcomes framework (QOF) showed that 90.8% of these patients had a care plan which had been reviewed in the last 12 months.

The practice carried out dementia reviews and some clinical staff had received additional training on how to care for people with mental health needs and dementia. The practice regularly worked with multi-disciplinary teams, including community psychiatric nurses and counsellors in the case management of people experiencing poor mental health. Patients were offered referral to emotional support services such as an in-house counselling clinic, a community mental health service, and a drug and alcohol addiction service.

# Summary of findings

## What people who use the service say

We spoke with seven patients, including a member of the patient participation group (PPG) on the day of our inspection. Most were positive about the practice and their experience of the services provided. Patients said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment. They told us they were happy with the cleanliness of the environment and the facilities available. They said they could get an appointment when they needed one and were complimentary about the practice's walk-in service as this accommodated patients who required urgent appointments the same day. However, two patients told us that the waiting time during the walk-in clinics were unpredictable and varied from 15 to 45 minutes. We received nine CQC comment cards for this practice. All comments were positive about the practice and staff.

Data from the national Patient Survey 2015 indicated that 96% of respondents described their overall experience of the practice as good, compared to the clinical commissioning group (CCG) average of 86% and national average of 85%. Respondents rated the practice above the CCG and national averages for their consultations with the GPs and nurses; questions about access to appointments, including their experience of making an appointment; and getting through easily to the surgery by phone. The practice was rated below average for patients stating they usually waited 15 minutes of less after their appointment time to be seen (practice 32%; CCG and national average 65%). Results from the Friends and Family Test December 2014 to March 2015 indicated that the majority of patients who responded were satisfied and would recommend the service.

# The Pembridge Villas surgery

**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, a practice manager specialist advisor, and a leadership fellow. The specialist advisors were granted the same authority to enter the registered persons' premises as the CQC inspector.

## Background to The Pembridge Villas surgery

The Pembridge Villas Surgery provides GP led primary care services through a Personal Medical Services (PMS) contract to around 10,100 patients living in the surrounding areas of Notting Hill, Bayswater and Westbourne Green. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS West London (Kensington and Chelsea, Queen's Park and Paddington) Clinical Commissioning Group (CCG).

The practice staff comprise of five GPs (two male GP partners; two male salaried GPs; and one female salaried GP), three practice nurses, a phlebotomist/health care assistant, a practice manager, an assistant practice manager, and a small team of receptionists and administrative staff. The number of sessions covered by the GPs equates to 4.76 whole time equivalent (WTE) staff, and the nurses 1.8 WTE staff. The phlebotomist/health care assistant worked 35 hours per week. There are also district nurses, health visitors, counsellors, a community psychiatric nurse, and a care navigator attached to the practice.

The practice is located in a converted residential property with five consulting rooms on the ground floor, and two on the first floor.

The practice is open every weekday from 08:45 to 18:30, except Wednesday afternoons when it is closed to general callers and only patients with pre-booked appointments are seen. From 08:00-08:45 patients who call the practice are directed to an out-of-hours GP service. The practice offers walk-in appointments from 08:45 to 10:00 and 16:00 to 18:30 every weekday except Wednesday afternoons. Bookable appointments are offered from 10:30 to 12pm and 13:30 to 16:00 every weekday. Extended hours were available for booked appointments from 18:30 to 20:00 on Monday, Tuesday, Wednesday and Thursday evenings, and on Wednesday morning from 08:00 to 08:30. The practice opted out of providing out-of-hours services to their patients. On Wednesday afternoons and outside of normal opening hours patients are directed to an out-of-hours telephone number, or the NHS 111 service.

The practice has a predominantly young adult population between the ages of 25 and 44. There is a higher percentage (than the national average) of patients aged 0 to 4, and a lower percentage of patients aged five to 18, and over the age of 65. There is a lower percentage (than the national average) of people with a long standing health condition (34.8% compared to 54%), and a lower percentage (than the national average) of people with health related problems in daily life (34.6% compared to 48.8%). The average male and female life expectancy for the CCG area is similar to that of the national average.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures; treatment of disease, disorder and injury; surgical procedures; family planning;

# Detailed findings

and maternity and midwifery services. The practice had previously been inspected during our pilot phase in May 2014, and we found shortfalls relating to the arrangements to ensure the dignity and privacy of service users.

## 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 and to look at the overall quality of the service. The practice had previously been inspected during our pilot phase in May 2014, and we have an obligation to conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

## How we carried out this inspection

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

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

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

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

Before visiting we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We also reviewed the practice's action plan following their previous inspection on 22 May 2014.

We carried out an announced inspection on 21 April 2015. During our inspection we spoke with a range of staff including: four GPs; two practice nurses; the health care assistant; the practice manager; the assistant practice manager; and a receptionist. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of four patients. We sought the views of seven patients, including a member of the patient participation group (PPG) on the day of inspection. We reviewed nine comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures.

Good

# Are services safe?

## Our findings

**Safe track record**

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a recent incident involved a specimen sample being sent for analysis with the incorrect patient details. The incident had been reported to the relevant staff members and investigated internally. Relevant external organisations were informed of the incidents, and the two patients involved were contacted. The incident was shared with other staff during a practice meeting.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred during the last four years and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the shared drive and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. We saw evidence of action taken as a result and that the learning had been shared. For example, a significant event was recorded when the computer system failed for 2.5 hours following the installation of a new software system. The practice utilised their business continuity plan and were able to adapt the service provided during the disruption. We saw evidence that the incident and learning points had been shared with staff at the next practice meeting. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were saved on the shared drive and disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, an alert from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding the prescribing of a painkiller had been actioned by recalling patients affected and changing their prescription.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. For example, the GPs had received Level 3 child protection training, the nurses Level 2 or 3, and non-clinical staff Level 1. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

A practice nurse had been appointed as the dedicated lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible in the waiting room. (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). Clinical and non-clinical staff carried out chaperone duties. Chaperone training was provided to all staff during the 2015 practice away day, and staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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 GPs were aware of vulnerable adults and worked with other health and social care professionals to manage the care of these patients. We saw minutes of meetings where vulnerable patients were discussed.

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

A 'repeat prescription and medication review protocol' was in place. Repeat prescriptions could be requested in person, online, via e-mail, post, fax or by pharmacist request. All requests were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice met with the community pharmacy advisor twice a year to discuss prescribing data. We saw minutes to these meetings that noted the actions to take in response to the review of prescribing data. For example, the GPs and nurses were advised to use a generic combined oral contraception medicine as an alternative to a branded version.

There was a system in place for the management of high risk medicines such as lithium, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. For example, the management of patients taking methotrexate was via a shared-care protocol with the hospital, and a contract which detailed the responsibilities of the specialist and the GP was in place. We also saw that audits for lithium and methotrexate were carried out to ensure medicines were prescribed safely. The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that were up to date.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw from the significant event records that a member of staff sustained a needle stick injury in March 2014 and the relevant occupational health protocols had been followed.

The practice had two leads for infection control and they had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff had received in-house training about

infection control specific to their role. We saw evidence that the leads had carried out audits and that any improvements identified for action were completed on time.

The practice had received an infection prevention and control visit from North and East London Commissioning Support Unit in February 2015. The audit confirmed the practice had written schemes for prevention of legionella (a bacterium that can grow in contaminated water and can be potentially fatal), and that risk assessments for legionella were being carried out. The audit also referred to areas that required improvement, such as replacing carpets in consulting rooms with impervious easy to clean flooring, and replacing chairs with fabric covers in clinical areas with chairs which comply with infection control guidelines. The practice had addressed the areas which required immediate attention.

Notices about hand hygiene techniques were displayed in clinical rooms, and hand washing sinks with soap, hand gel, and hand towel dispensers were also available.

**Equipment**

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was tested and displayed stickers indicating the last testing date which was December 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment in May 2015; for example thermometers and blood pressure monitors.

**Staffing and recruitment**

The practice had a recruitment policy that set out the standards it followed when recruiting staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There had been very little turnover of GPs over the last few years which enabled good continuity of care. The practice manager told us that the recruitment of nursing staff had previously been a problem, however an additional nurse and health care assistant had recently been employed to ensure consistency of nursing staff. There were also arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety lead. Health and safety audits were completed each year and we reviewed completed audits for the last two years. Follow-up actions were recorded and updated by the health and safety lead.

The practice kept paper and electronic patient records. Electronic records were password protected and could only be accessed by authorised staff. Patients' paper records were stored securely.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. There was a policy in place for checking the emergency drugs and equipment, and emergency protocols, such as the management of anaphylaxis, were displayed within consultation rooms. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Good

# Are services safe?

Emergency medicines were easily accessible to staff within each treatment room and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, incapacity of staff, and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the computer software company in the event of a system failure.

The practice had undergone an independent fire assessment in 2012. The health and safety lead carried out annual fire risk assessments that included actions required to maintain fire safety. Records showed that staff received in-house fire safety training in 2013.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Two GPs underwent annual training to update them on new guidance, and this information was disseminated to other practice staff. Another GP took responsibility for attending clinical commissioning group meetings and local Clinical Learning Sets (CLS) where appropriate guidelines were discussed. We saw evidence which showed this information was shared with staff and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks with the GPs and nurses. The practice's performance was above the CCG and national averages for patients with diabetes who had a blood pressure reading in the preceding 12 months of 150/90 mmHg or less (practice 95.8%, CCG 90.9%, national 91.7%); patients with diabetes with a record of a foot examination and risk classification within the last 12 months (practice 95.3%, CCG 88.5%, national 88.3%); and patients with diabetes who had received the seasonal flu vaccination (practice 96.2%, CCG 88.9%, national 93.4%). Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as long term conditions and the practice nurses supported this work. There were also GP leads for the care of certain population groups, such as children and homeless patients. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of patients with impaired renal function. Our review of the correspondence between clinical staff confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

**Management, monitoring and improving outcomes for people**

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The GPs collated information to support the practice to carry out clinical audits.

The practice showed us 11 clinical audits that had been undertaken in the last three years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. We reviewed an audit of the monitoring of patients on immunosuppressant drugs. The initial audit had been carried out in November 2012, and a re-audit took place in February 2014. The initial audit had identified 31 patients on the specified drugs, 45% of these patients had evidence of correct monitoring whereas 55% had no firm evidence of monitoring (for example, they had been seen in clinic but blood tests were not mentioned). Action was taken to review the patients records to ensure they were summarised appropriately and the notes were marked with an alert of the drug and monitoring requirements. The information was shared with the other GPs at the practice.

Good

# Are services effective?

## (for example, treatment is effective)

The re-audit showed that the number of patients on the drugs had reduced to 20, and patient outcomes had improved as 75% of patients were being correctly monitored.

The practice was registered with the CQC to perform minor surgery. The GP undertook minor surgical procedures in line with their registration and NICE guidance. They carried out regular clinical audits on their results and used that in their learning. We saw that information from audits was shared with clinical staff by email, and discussed at practice meetings.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from 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 and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of lithium. Following the audit, the GPs carried out medication reviews and blood tests for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 99.9% of the total QOF target in 2014, which was above the clinical commissioning group average of 89%, and the national average of 93.5%. This included achieving 100% (609.88 out of 610 points) for the clinical domain, where most performance indicators for conditions such as chronic obstructive pulmonary disease (COPD), dementia, depression, diabetes, and hypertension were better than the local and national averages.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, such as homeless patients and patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions such as diabetes, COPD and asthma. QOF data showed that the practice were above the CCG and national averages for the percentage of patients with COPD who had received a review, including assessment of breathlessness in the preceding 12 months (practice 91.8%; CCG 87.8%; national 89.6%). QOF data also showed that the practice were below the CCG and national averages for patients who had received an asthma review in the preceding 12 months (practice 72.1%; CCG 75.6%; national 75.5%).

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, in antibiotic prescribing, GP referred outpatient attendances, and emergency admissions.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with some having additional diplomas in family planning, children's health, and obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was

proactive in providing mandatory training and support for continuing professional development. Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Practice nurses and the health care assistant had job descriptions outlining their roles and responsibilities. We saw they were trained appropriately to fulfil these duties, for example administering vaccines and carrying out cervical smears.

**Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Out-of hours reports, 111 reports and urgent pathology results or letters were seen and actioned the same day they were received by the duty doctor. Non-urgent correspondence was reviewed by the patient's named GP, who was responsible for the action required. If a GP was on leave, their correspondence would be checked by another GP. All staff we spoke with understood their roles and felt the system in place worked well. We were told there were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 5.46% compared to the national average of 14.4%. The practice was commissioned for the unplanned admissions enhanced service and we were told that care plans were completed for 2% of their most vulnerable patients, in line with the requirements for the enhanced service. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We reviewed the care plan for one of these patients and found it had been comprehensively completed.

The practice held monthly case management meetings and bimonthly full meetings with a multidisciplinary team to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, counsellors, health visitors, community psychiatric nurses, palliative care nurses, and a care navigator, to discuss care planning for these patients, and we reviewed minutes to some of these meetings. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs, such as those in receipt of palliative care, with the out-of-hours services. Electronic systems were also in place for making referrals via the local referral pathways, and the Choose and Book system.

The practice had signed up to the electronic Summary Care Record system. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Information on this was available in the waiting room, and we were told patients were offered the choice to opt out if they did not want their records shared in this way.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

The practice cared for patients with learning disabilities from a local care home. We were told that patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in

clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The practice had a consent policy which set out its approach to gaining consent. The policy outlined the difference between implied and expressed consent, and also provided guidelines for staff with regard to Gillick competency. The policy also made reference to documenting consent for specific interventions. For example, a patient's written consent was obtained for all minor surgical procedures, and this was then scanned into the electronic patient notes. The staff we spoke with were clear about when to obtain written consent.

**Health promotion and prevention**

It was practice policy to offer a health check to all new patients registering with the practice. Patients aged 16-25 years were offered chlamydia screening during their check-up. The GPs were informed of all health concerns detected during the new patient health check and these were followed up in a timely way. A blood pressure pod was available in the waiting room and patients were encouraged to take their blood pressure before seeing the doctor. Instructions on how to use

the machine and print results were provided.

We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering advice on disease management, diet, smoking cessation, and alcohol intake. Health promotion information was available to patients in the waiting room, consulting rooms, and on the practice website.

The practice had ways of identifying patients who needed additional support. For example, patients aged 85 or over were offered an annual health check. The practice also kept a register of all patients with a learning disability. Practice records showed that three out of seven had received a check up in the last 12 months. Data from the quality and outcomes framework (QOF) indicated the practice exceeded the national average for having a comprehensive care plan in place for patients with schizophrenia, bipolar affective disorder and other psychoses achieving 90.8% compared to the local average of 83.6% and national average of 85.9%. It was slightly below the national average for the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months, achieving 80% compared to the local (83.2%) and national averages (83.8%).

Annual physical checks and mental health reviews were offered to patients on the mental health register, and data from the QOF showed that 90.8% of these patients had a care plan which had been reviewed in the last 12 months. The practice had a palliative care register and these patients received end of life care and further support in line with their needs.

Dedicated clinics were offered to patients with chronic conditions such as asthma, diabetes, and heart disease. These were carried out by the GPs and nurses, and we were told that patients were invited for an annual health review.

The practice's performance for the cervical screening programme in the preceding year was 88.1%, which was above the local average of 77.4% and national average of 81.9%. Reminders were sent for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for flu vaccinations was above the national averages where comparative data was available. For example, flu vaccination rates for the over 65s was 80.6% (national average 73.24%), and at risk groups was 78.29% (national average 52.29%).

The practice also offered a weekly baby clinic with the GPs and a health visitor, and the nurses provided childhood immunisations. Last year the practice's childhood immunisation rates ranged from 66.3% to 84.9% for children aged under 12 months; 77.3% to 89.2% for under twos; and 76.3% to 94.7% for five year olds. Performance for all childhood immunisations was above average for the

Good

# Are services effective?

## (for example, treatment is effective)

CCG, for example 83.5% of children aged 24 months had received an MMR vaccination (CCG average 75.9%); and 85.1% of 5 year old children had received the Dtap/IPV Booster (CCG average 64.1%).

Antenatal and postnatal care was offered as part of a shared care programme with the hospital. The practice had a comprehensive pregnancy information pack which was given to women as part of their antenatal care. The pack included information on the antenatal shared care programme between the practice and the hospital, a healthy pregnancy book, and information on diet and lifestyle advice during pregnancy.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015 (93 responses received), a patient satisfaction survey carried out by the practice in March 2015 (150 responses received), and results from the Friends and Family Test (a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses). The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

Data from the national GP patient survey 2015 showed that the practice was above the CCG and national averages for patient satisfaction scores on consultations with the GPs. For example, 93% of respondents said the GP was good at listening to them compared to the CCG and national average of 89%. Ninety three percent said the GP gave them enough time compared to the CCG average of 85% and national average of 87%. Satisfaction scores for consultations with the nurses was also above the CCG and national averages. For example, 96% of respondents said the nurse was good at listening to them (CCG average 86%, national average 91%), and 98% said the nurse gave them enough time (CCG average 87%, national average 92%).

Results from the Friends and Family Test December 2014 to March 2015 indicated that the majority of patients who responded were satisfied with the service they received. For example, in February 46 patients said they were 'extremely likely' or 'likely' to recommend the service, and two said they were 'extremely unlikely' to. In March the figures were 22 and one respectively. There was a range of Information leaflets in reception to help patients understand the services available.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection, and one member of the Patient Participation Group. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical and non-clinical staff. Results from the practice's survey aligned with these views.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy screens were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that a private area within the practice could be used to prevent patients overhearing potentially private conversations between patients and reception staff. Confidential calls were made from the administration office which was located away from the reception area. The national GP patient survey showed that 91% of respondents found the receptionists at the practice helpful compared to the CCG average of 86% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

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

The national patient survey 2015 showed that respondents rated the practice above the CCG and national averages to questions about their involvement in planning and making decisions about their care and treatment. For example, 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 81%. Ninety percent said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.

Satisfaction scores for consultations with the nurses were similar to or above the CCG and national averages. For example, 84% said the nurse was good at involving them in

Good

# Are services caring?

decisions about their care (CCG average 79%, national average 85%), and 91% said the nurse was good at explaining tests and treatments (CCG average 83%, national average 90%).

All the patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment cards we received was also aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language, and there were notices informing patients this service was available. Some staff could also speak languages other than English, which aided communication with some patients.

**Patient/carer support to cope emotionally with care and treatment**

Patients were offered referral to emotional support services such as an in-house counselling clinic, a community mental health service, and a drug and alcohol addiction service. Patients were also signposted to other voluntary organisations and a befriending service.

The national patient survey showed that respondents rated the practice similar to or slightly above the CCG and national averages for the emotional support provided by the practice. For example, 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%. Ninety three percent said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 90%.

None of the patients we spoke with on the day of our inspection or who completed the CQC comment cards mentioned emotional support or treatment however notices in the patient waiting room and on the practice website told patients how to access a number of support groups and organisations.

The percentage of patients with a caring responsibility was lower than the national average at 12.8% compared to 18.2%. The practice's computer system alerted GPs if a patient was a carer, and carers were offered health checks and the flu vaccination. A carer's policy was in place, and information on the various avenues of support for carers was made available in the waiting room.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The GP partners told us that they engaged regularly with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, chronic disease management clinics were run by the GPs and nurses and the practice were proactive in inviting patients for an annual health review. The practice had started planning for the 'out-of-hospital services' whereby additional services including ambulatory blood pressure monitoring, phlebotomy, care planning, and spirometry were offered to patients within the GP practice environment. The practice had reviewed the services they were able to offer their own patients and patients from local practices, and we were told this would come into effect later this year.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the group had suggested that it was difficult for patients to access the nurse to receive their test results within the daily hourly time slot. The practice, in collaboration with the PPG, reviewed the system and created additional afternoon sessions for patients to call the practice to receive their results. They also made patients aware of the new system by producing flyers in the waiting room and information on the website.

We spoke to a member of the PPG during the inspection. Their feedback was positive with regard to how the practice implemented changes following feedback from patients and the PPG. For example, the practice had improved signage within the waiting room and had designated seating for patients with mobility needs. They had also provided more information to patients on the appointment system, and we saw laminated cards informing patients with more than two conditions to book appointments rather than use the walk-in service. We were told that this was to ensure there was adequate time for patients to discuss their concerns, and to reduce waiting times during the walk-in clinics.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, mental health conditions, and multiple complex conditions. The practice looked after patients with learning disabilities from a local care home. There was a named GP for these patients, and patients were also given the choice to see any GP at the practice. We were told the practice also supported patients from a local women's shelter that were fleeing domestic violence.

The practice recognised the needs of homeless patients by offering them an extended registration health check which included screening for mental health problems, drug and alcohol issues, and infectious diseases. One of the GP partners also ran a charity which provided supported housing to 25 formerly homeless people. Many of these patients were previously registered at a surgery which specialised in caring for homeless people, and was run by the GP partners. These patients were allowed to register with the practice despite their supported housing being located outside of the geographical boundaries for the practice. We were told this was so patients would benefit from the continuity of care and the relationships they had built up with the GPs. The GPs we spoke with had a good knowledge of the health challenges experienced by homeless patients and three GPs had further experience of working in another practice which provided healthcare services specifically for homeless people

We were told that patients registering with the practice could be seen the same day, and on most occasions also have their new patient health check done. The majority of the practice population were English speaking patients but access to telephone translation services was available if they were needed.

The practice was based in a converted residential property with five consulting rooms on the ground floor, and two on the first floor. Some adaptations had been made to the premises to assist patients with mobility difficulties. For example, there was a handrail and a ramp at the entrance, an electronic push button for the front door, and a stair lift

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

between the different levels on the ground floor. Access to the consulting rooms on the first floor was via stairs and we were told that patients with mobility difficulties were accommodated so that they were seen in one of the ground floors rooms. There was a large waiting area with space for wheelchairs and prams. Accessible toilet facilities were available for patients attending the practice and included baby changing facilities.

Staff told us that they registered patients with no fixed abode so that they could access the service. There was a system for flagging vulnerability in individual patient records. For example, to identify patients who were housebound, receiving palliative care, or patients with learning disabilities. All patients over the age of 75 had a named GP and were informed of this in writing.

Patients could choose to see a male or female GP. The practice had an equality and diversity policy in place and staff had received in-house training. Staff we spoke with confirmed that equality and diversity was regularly discussed at practice meetings.

**Access to the service**

The practice was open every weekday from 08:45 to 18:30, except Wednesday afternoons when it was closed to general callers and only patients with pre-booked appointments were seen. From 08:00 to 08:45 patients who contacted the practice were directed to an out-of-hours GP service. The practice offered walk-in appointments from 08:45 to 10:00 and 16:00 to 18:30 every weekday except Wednesday afternoons. Bookable appointments were offered from 10:30 to 12pm and 13:30 to 16:00 every weekday. Extended hours were available for booked appointments from 18:30 to 20:00 on Monday, Tuesday, Wednesday and Thursday evenings, and on Wednesday morning from 08:00 to 08:30. These were particularly useful to patients with work or educational commitments, as the practice had a higher percentage of patients in paid work or full-time education (69.2%) compared to the national average (60.2%). Appointments could be booked in advance over the telephone, online or in person. Text message reminders for appointments were sent to patients who consented to this service. Comprehensive information was available to patients about appointments in the practice leaflet and on the website. This included how to arrange home visits and how to book appointments through the website. A timetable of when clinical staff worked was on display in the waiting room and on the website so that patients could see their preferred GP or nurse. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. On Wednesday afternoons and outside of normal opening hours patients were directed to an out-of-hours telephone number, or the NHS 111 service. Information on the out-of-hours service was provided to patients.

Longer appointment times were available for those who may need them including patients with complex conditions; antenatal and postnatal care; and annual reviews for patients with long term conditions such as diabetes and asthma. Home visits were made to patients who needed one, including housebound patients, and the frail elderly. We were told that telephone consultations were also provided to patients who found it difficult to access the practice.

The national patient survey 2015 information we reviewed showed patients rated the practice above the CCG and national averages for questions about access to appointments. For example, 81% were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%; 87% described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%; and 89% said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 73%. The practice was rated below average for patients stating they usually waited 15 minutes of less after their appointment time to be seen (practice 32%; CCG and national average 65%). Staff told us this low rating was most likely due to waiting times during the walk-in clinics where patients were seen on a first-come first-served basis. The practice were looking into ways of making the walk-in service run more efficiently, for example informing patients to come in at particular times and to book appointments if they had more than two issues to discuss.

All the patients we spoke with were satisfied with the appointments system and said it was easy to use and they could get an appointment when they needed one. Patients confirmed that they could see a doctor on the same day via the walk-in service and were aware that this might not be with the GP of their choice. They told us there was often a wait to be seen during the walk-in clinics, but they felt the walk-in service was flexible and met their needs.

**Listening and learning from concerns and complaints**

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had a system 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. Complaints were discussed in staff meetings, or sooner if required, and staff we spoke with were able to outline what to do if a complaint was made to them. Staff told us that wherever possible they tried to de-escalate problems and deal with concerns immediately.

We saw that information was available to help patients understand the complaints system in the practice leaflet, a complaints leaflet and on the website. Some patients we spoke with were aware of the process to follow if they wished to make a complaint, and others told us they would request the information from staff. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice provided us with a copy of its annual complaints report for 2015. The report indicated that five complaints were received in the last 12 months. The practice had documented the action taken and learning achieved. For example, a patient had complained that there was a 20 minute delay in being seen for a booked appointment. The incident was investigated and shared with the member of staff, and a GP partner spoke directly to the patient to apologise and resolve the issue. The staff member's workload was reviewed to see if their time could be managed more appropriately to prevent delays. All five complaints had been handled satisfactorily and in a timely way. No themes had been identified during the annual complaints review. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. We saw from minutes of team meetings that complaints were discussed to ensure all staff were able to learn and contribute to any improvement action that might be required.

# 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. This strategy included providing a high quality service which was accessible, personal, flexible and responsive to the practice population. Over the last 11 years the practice had seen its list size increase from 3,000 to 10,000 patients, and this had had an effect on the capacity of the practice to meet patient demands for appointments and the services it could offer. As a result the practice was in the process of bidding for new premises to meet this demand.

The 'out-of-hospital services' were a priority for the practice and were incorporated into their strategy. We looked at minutes of the 2015 practice away day and saw that the practice had reviewed the services they were able to offer, assigned staff members to manage each service, and identified training requirements for staff. All the staff we spoke with knew and understood the practice's vision and values and knew what their responsibilities were in relation to these.

**Governance arrangements**

The practice had a number of policies and procedures in place to govern activity and these were available to staff on a shared drive accessible on any computer within the practice. We looked at a number of these policies and procedures, including those relating to safeguarding, infection control, health and safety, fire safety, consent, complaints, and business continuity. These had been reviewed annually and were up to date, and staff we asked knew how to locate these documents.

There was a clear leadership structure with named members of staff in lead roles. For example, there were lead nurses for infection control and safeguarding; a GP to lead on QOF; a designated member of staff to lead on health and safety; and the practice manager led on complaints. Staff we spoke with were all clear about their own roles and responsibilities and knew who the various leads were. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. They also felt there were involved in decision making where appropriate.

The GP partners, a salaried GP, and the practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards and had achieved 899.19 points out of a total of 900 for the year 2014. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. We reviewed examples of completed audits regarding lithium prescribing, vitamin D prescribing, and monitoring of patients on immunosuppressant drugs. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the clinical commissioning group (CCG).

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. For example, risks relating to fire safety, business continuity, and infection control had been carried out. The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of documents, including an induction policy and the staff handbook which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

**Leadership, openness and transparency**

# Are services well-led?

Good

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

The partners and practice manager were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff were encouraged to contribute to discussions about how to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt supported if they did. We also noted that team away days were held every year. Staff said they felt respected, valued and supported, particularly by the practice manager and the GP partners.

**Practice seeks and acts on feedback from its patients, the public and staff**

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through surveys, complaints received, and the patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). It had an active PPG which included representatives from various population groups including: older people; people with long-term conditions; parents of young children; people experiencing poor mental health; and people whose circumstances may make them vulnerable. There was also a representative for patients from a local learning disability home.

There was a lead GP who corresponded with the PPG. The PPG carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys was on display in the waiting room. Common themes emerging from feedback related to the difficulty patients reported in accessing their results over the phone, and letting patients in early prior to the walk-in clinic commencing. The practice had taken action by adding an extra afternoon slot where patients could receive their results from the nurses. However, letting patients in early remained an ongoing issue and the practice continued to look at ways to address this. For example, putting posters up to inform patients of the reasons why this was currently not possible.

Members of the PPG also attended Healthwatch locality meetings. The purpose of these meetings was to bring PPG representatives from different practices together to discuss how they communicated with their groups and to develop ideas for future improvements. We saw minutes from a meeting in January 2015 where the practice received positive feedback from their PPG representative. We also spoke with a member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

Data from the national GP patient survey 2015 showed that 96% of respondents described their overall experience of the practice as good, compared to the clinical commissioning group (CCG) average of 86% and national average of 85%. We saw evidence that the practice had reviewed its results from the national GP survey and the Friends and Family test to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through an annual away day and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan (PDP). We saw that the PDPs were reviewed and acted on. For example, one of the nurses was doing a 'physical assessment' course as a result of lasts years PDP, and one of the GPs was supporting and supervising her in doing this. We also saw from email correspondence that the GPs shared their learning with the other GPs following attendance at training courses and educational events. Staff told us that the practice was supportive of training and that they had staff away days where further training was provided.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw from minutes that discussion of significant events and their outcome was a standing item on the agenda of the practice meetings. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings.