Guttridge Medical Centre

Quality Report

Guttridge Medical 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

Contents

Summary of this inspection — Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 7

What people who use the service say 11

Areas for improvement 11

Detailed findings from this inspection

Our inspection team 12

Background to Guttridge Medical Centre 12

Why we carried out this inspection 12

How we carried out this inspection 12

Detailed findings 14

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Guttridge Medical Centre (Dr Yerra's Surgery) on 4 April 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. Actions taken as a result of significant events were reviewed in a timely way.
- The practice had clearly defined and embedded systems to minimise risks to staff and patient safety. One of the neighbouring practices checked the shared emergency equipment to ensure that it was safe to use and fit for purpose although the practice had not had sight of these checks before our inspection.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However, records of staff training were incomplete and there was no documented training programme to govern training.
- All staff had had an appraisal within the last 12 months although the appraisal process for one staff member needed review to allow in-house appraisal.
- The practice premises were new and had been designed to present no risks to staff working or to patients. The practice told us that they planned to produce health and safety risk assessments in the Summer of 2017 for ongoing assessment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns. The practice had stopped recording verbal complaints and told us that they would resume recording following our inspection.

Summary of findings

- Patients we spoke with said they usually found it easy to make an appointment with the GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs. The surgery building was newly converted and had been designed for purpose.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Maintain an overview of checks carried out on emergency equipment in the building.
- Provide an overall programme to govern staff training activity, including timescales, and keep an accurate record of all staff training.
- Complete the health and safety risk assessments for premises safety and staff working as planned.
- Recommence recording patient verbal complaints in order to monitor trends.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to staff and patient safety. The practice had adequate arrangements to respond to emergencies and major incidents. One of the neighbouring practices checked the shared emergency equipment to ensure that it was safe to use and fit for purpose although the practice had not had sight of these checks before our inspection.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role although training records were incomplete.

Are services effective?

The practice is rated as good for providing effective services.

Good

- Data from the Quality and Outcomes Framework showed patient outcomes were generally at or above average compared to the national average.
- Staff were aware of current evidence based guidance and used this to deliver care and treatment.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff although the appraisal process was in need of revision for one staff member.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved. Staff were trained in end of life care.

Are services caring?

The practice is rated as good for providing caring services.

Good

Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for most aspects of care.
- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice was flexible with appointments for baby vaccinations and immunisations and offered them outside clinic times for those who could not attend. They offered longer appointments for those patients who needed translation services.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from the example we reviewed showed the practice responded well to issues raised. Learning from complaints was shared with staff. The practice had stopped recording verbal complaints and told us that they would resume this following our visit.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. The overview of staff training, however, was incomplete and there was a lack of a formal training programme for all aspects of staff training.
- The provider was aware of the requirements of the duty of candour. In four examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice produced personalised care plans which could be shared with local care services such as the ambulance service and the out of hours service.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. The practice offered health checks to patients aged over 75 who were not already registered for a routine health check. The practice also made patient referrals to the local social care service.
- The practice always tried to find time for a GP appointment, if requested, for elderly patients who were attending the premises for other services, to save an additional journey to the surgery.
- The practice gave a dedicated telephone number to the local A&E department and nursing home for urgent communications.

People with long term conditions

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

- The practice nurse was trained in all aspects of long-term disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- Performance for diabetes related indicators was comparable to the local average of 88%. The practice achieved 87% of the indicators for the management of patients with diabetes.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice provided a point-of-care blood monitoring service for patients in the local area, including practice patients, who were taking certain medications.
- At the time of inspection, the practice was working on being able to provide a one-stop clinic for diabetic patients with input from the podiatry service, the GP and the practice nurse.

Families, children and young people

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

Good

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were high for all standard childhood immunisations. This achievement had been recognised by Public Health England, Screening and Immunisation department.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Summary of findings

- Staff sent letters to new mothers enclosing a new registration form for the baby and giving them details of the baby's vaccination and immunisation programme and health checks.
- There was a dedicated room in the practice for breastfeeding mothers.

Working age people (including those recently retired and students)

Good

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example Saturday morning appointments. At the time of the inspection, the practice was in discussions with neighbouring practices regarding further provision of extended hours appointments.
- The practice nurse provided patient appointments until 6pm on a Tuesday and the GP would offer a late appointment for a patient on the basis of individual need.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- Telephone appointments with GPs were available in addition to face-to-face appointments.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability and those with complex needs.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.

- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice carried out advance care planning for patients living with dementia.
- 82% of patients diagnosed with dementia had their care reviewed in a face-to-face meeting in the last 12 months, which was lower than the national average of 84% but the practice had not excluded any patients from this indicator.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. All these patients were invited to the practice annually for a review of these needs.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 94% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the national average of 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia. Staff had trained in dementia awareness.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing better than local and national averages. A total of 348 survey forms were distributed and 89 were returned (26%). This represented 4.5% of the practice's patient list.

- 90% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 87% and the national average of 85%.
- 89% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 83% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 42 comment cards which were all positive about the standard of care received. Patients wrote that staff were caring, supportive and professional and said that it was an excellent service that was always helpful and empathic. One card said that they felt that they had not had such a good service "since they were little". There were four cards that also mentioned that getting an appointment could sometimes be difficult and one that said that they struggled with car parking.

We spoke with one patient during the inspection and three patients on the telephone on the following day. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Results of the Friends and Family test showed that in the months of April 2016 to February 2017, 137 out of 149 patients (92%) who completed the survey would be extremely likely or likely to recommend the practice to friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Maintain an overview of checks carried out on emergency equipment in the building.
- Provide an overall programme to govern staff training activity, including timescales, and keep an accurate record of all staff training.
- Complete the health and safety risk assessments for premises safety and staff working as planned.
- Recommence recording patient verbal complaints in order to monitor trends.

Guttridge Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Guttridge Medical Centre

Guttridge Medical Centre (Dr Yerra Surgery) is situated on the Deepdale Road in Preston at PR1 6LL serving a mainly urban population. The building is a newly-converted church that has been occupied by the practice since August 2016. The practice shares the building with two other single-handed GP practices, a physiotherapy service and a pharmacy. The practice provides level access for patients to the building with disabled facilities available, fully automated entrance doors and a ramp to the reception desk to facilitate wheelchair access. Part of the reception desk is lowered to aid patient access.

The practice has parking for disabled patients and there is parking available on nearby streets for all other patients, and the surgery is close to public transport.

The practice is part of the Greater Preston Clinical Commissioning Group (CCG) and services are provided under a General Medical Services Contract (GMS) with NHS England. There is one male GP principal and one female long-term locum GP who provides one surgery session each week. A practice nurse, a practice manager, a head receptionist and three additional administrative and reception staff, one of whom is also the practice medicines co-ordinator, assist them.

The practice doors open from Monday to Friday from 8.30am to 6pm and telephone access to the practice starts at 8am and finishes at 6.30pm. Appointments are offered from 9.20am to 11.45am and from 3.30pm to 5.25pm on all weekdays except Thursday, and from 9.30am to 11.45am on Thursday. There is a rota for the three GP practices in the Medical Centre to cover any patient emergency appointments, including home visits, on a Thursday afternoon. The practice also offers extended hours appointments on one Saturday each month from 9am to 12noon. When the practice is closed, patients are able to access out of hours services offered locally by the provider GotoDoc by telephoning 111.

The practice provides services to 1,964 patients. There are considerably lower numbers of patients aged over 65 years of age (9%) than the national average (17%) and higher numbers of patients aged under 18 years of age (26%) than the national average (21%). The practice also has more patients aged between 30 and 49 years of age (33%) than the national average of 28%, the majority of these being male.

Information published by Public Health England (PHE) rates the level of deprivation within the practice population group as three on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The ethnicity estimate given by PHE gives an estimate of 2.5% mixed and 37.6% Asian.

The practice senior full-time GP partner left the practice in December 2016 and the part-time GP partner became full-time. At the time of inspection, the practice was in the process of changing its registration with CQC from a partnership to a sole provider.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 4 April 2017. During our visit we:

- Spoke with a range of staff including the principal GP, the practice nurse, the practice manager and two members of the practice administration team.
- Spoke with one patient who used the service. We spoke to three further patients on the telephone on the following day who were also members of the practice patient participation group.
- Observed how patients were being cared for in the reception area and talked with carers and family members.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a comprehensive system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a verbal or written apology and were told about any actions to improve processes to prevent the same thing happening again. Patients were invited into the surgery for a face-to-face discussion of events where appropriate.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events and all actions taken as a result of significant events were reviewed to ensure that they were effective.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the process for prescribing hormonal contraception to some new mothers was changed after a significant event when a prescription was issued to a patient who was unaware or did not disclose that they were pregnant again.

Overview of safety systems and processes

The practice generally had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff on the practice shared drive. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare and lists of contact numbers were available to staff on the reception office noticeboard and online. The principal GP was the lead member of staff for safeguarding. We were told by staff that the GP attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff we interviewed demonstrated they understood their responsibilities regarding safeguarding and were able to provide examples of safeguarding concerns. We were told that all staff had received training on safeguarding children and vulnerable adults relevant to their role, however, an overview of training records failed to evidence this for two non-clinical staff. We were sent evidence following our inspection to show that this training had been completed. The GP and practice nurse were trained to child protection or child safeguarding level three.
- Notices in the waiting room and in all clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw that the most recent audit had not identified any actions to be taken as result. The practice attributed this to the fact that the premises had been refurbished to current infection prevention and control guidelines in 2016.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

Good

Are services safe?

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed either manually or electronically before being dispensed to patients and there was a reliable process to ensure this occurred. The practice medicines co-ordinator carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow the nurse to administer medicines in line with legislation.

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and all staff had received training in health and safety awareness. The practice had not carried out any risk assessments for premises and safe staff working since they moved into the building in August 2016. We were told that this was because the practice premises were new and had been designed to present no risks to staff working or to patients. The practice told us that they planned to produce health and safety risk assessments in the Summer of 2017 for ongoing assessment.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. Staff had been trained in how they could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. The practice staff were part time and could generally cover each other in times of staff absence. The GP had a buddy arrangement with the other GPs in the building to ensure that patient emergencies were covered in time of unexpected absence.

Arrangements to deal with emergencies and major incidents

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

- There was an emergency call system on the wall of all the rooms in the practice which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. They shared these with the other practices in the building. Arrangements had been made so that one of the other GP practices monitored this equipment and records of checks made were not kept with the equipment. The practice had not had sight of these records and had not assured themselves that checks had been made appropriately. We saw that monitoring was comprehensive and that equipment was in a suitable condition to treat medical emergencies. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The practice had developed its own clinical protocols which were updated appropriately.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 93% of the total number of points available, the same as the clinical commissioning group (CCG) average and comparable to the national average of 94%. Exception reporting was 2.9% which was considerably lower than the local CCG level of 9.6% and national average of 9.8%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to or lower than the local and national averages. For example, blood measurements for diabetic patients (IFCC-HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 76% of patients had well controlled blood sugar levels compared with the CCG and national average of 78%. The practice had not exception reported any patients for this indicator. Also, the percentage of patients with blood pressure readings within recommended levels (150/90 mmHG or less) was 81% compared to the CCG average of 87% and national average of 86%. However, exception reporting for these patients was also lower (1.3%) than the CCG average of 4.9% and the national average of 5.5%. The practice was aware that performance for diabetic related indicators was in need of improvement in some areas and was working to address this. They were planning to introduce a diabetic clinic that could provide a single appointment for patients with input from a podiatrist, the GP and practice nurse.
- Performance for mental health related indicators was generally higher than the local and national averages. For example, 94% of people experiencing poor mental health had a comprehensive, agreed care plan documented in the record compared to the CCG and national average of 89%. Also, 82% of patients diagnosed with dementia had their care reviewed in a face-to-face review compared to the CCG average of 86% and national average of 84%, although the practice had not exception reported any patients for this indicator.

There was evidence of quality improvement including clinical audit:

- There had been four clinical audits commenced in the last two years, one of these was a completed audit where the improvements made were implemented and monitored and this audit was still ongoing.
- Findings were used by the practice to improve services. For example, recent action taken as a result included the reduction in the prescribing of vitamin B12 for between 25% and 50% of patients at different times in the ongoing audit.
- The practice had noted that patient attendance at the local A&E department was increasing. At the time of our inspection, the practice was coding perceived inappropriate patient attendances on the practice computer system so that an audit could be conducted and patients contacted as necessary.

Information about patients' outcomes was used to make improvements such as encouraging elderly and frail diabetic patients to use blood monitoring machines at home and communicate the results to the practice so that hypoglycaemia (very low blood sugar levels) could be avoided. (Hypoglycaemia can cause falls and injuries in the elderly and frail patient).

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We saw evidence of a very comprehensive induction programme that introduced staff to all aspects of general practice over three sessions. This included the structure of the NHS and Primary Care, security, training, appraisal and significant event reporting.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Clinical staff had trained in awareness of the Mental Capacity Act 2005 and end of life care and non-clinical staff had trained in dementia awareness, chaperoning and customer care.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. We saw that all update training for clinical staff was up to date.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months, however, the appraisal process for one member of staff was conducted with a peer group of staff at the same management level in the building, not with the principal GP. We were told that with a new principal GP in a full-time position in the practice, there would be a follow-up meeting to complete the appraisal process.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules, in-house and external training. We found that staff showed comprehensive knowledge of this training; however, training prior to 2016 was not always recorded. There was no comprehensive overall training matrix to govern training or specific training programme. The practice had recently purchased a new online training system that staff had been using. This accurately recorded all training and allowed for a full programme and overview of training to be kept. We were told that formalising a training programme and recording training would be simplified using this system.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of two documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice nurse contacted vulnerable patients discharged form hospital to check that their needs were met and referred to other health and social care professionals as necessary. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health and social care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

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

Are services effective?

(for example, treatment is effective)

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and patients with mental health needs.
- Smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 82%, which was comparable with the CCG average of 79% and the national average of 81%. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. The practice was aware that uptake for these programmes was relatively low, even allowing for their younger patient demographic. They recorded non-attendance on the practice computer system and encouraged attendance for those patients at practice appointments. The practice gave a telephone number to patients who did not attend the bowel screening programme so that they could re-engage with the programme.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were high when compared to CCG averages. For example, from child health surveillance figures for the previous 12 months, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 97% compared to the CCG averages of 89% to 94%. Figures for five year olds ranged from 88% to 100% compared to the CCG averages of 82% to 95%. We saw an email in recognition of this achievement from the local Public Health England, Screening and Immunisation department inviting the practice to present at a Sharing Best Practice event in March 2017. The practice told us that their success was due to being flexible in offering vaccination and immunisation appointments outside of the clinic times when a family was struggling to attend. They had also introduced a letter that stressed the importance of having the vaccinations and encouraged them to re-consider their decision. This letter was given out with information leaflets when patients declined a vaccination.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice also carried out health checks for all patients aged over 75 who were not already registered for a routine health check and had completed 60% of these at the time of the inspection. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. This was advertised to patients on a poster in the patient waiting area.
- A clinician of the same sex could treat patients. The practice made appointments with the female locum GP on a Thursday if patients requested this.

All of the 42 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One card said that they felt that they had not had such a good service "since they were little".

We spoke with four patients including three members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 94% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 90% of patients said the nurse was good at listening to them compared with the CCG and the national average of 91%.
- 87% of patients said the nurse gave them enough time compared with the CCG and the national average of 92%.
- 98% of patients said they had confidence and trust in the last nurse they saw compared with the CCG and the national average of 97%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals. All non-clinical staff had been trained in-house in the care of unaccompanied young people and clinical responsibilities relating to the recognition of competency.

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

- 89% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG and the national average of 86%.

Good

Are services caring?

- 89% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 90% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 94% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them. The practice made longer appointments when necessary for patients who needed translation services. All new patients were given a short form that included a question to ask what their main language was.
- The practice website included a translation service that allowed for the contents to be translated into different languages.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.) The surgery staff were aware of patients who might struggle to make appointments for themselves and booked appointments on their behalf when needed.
- The practice provided many patient information leaflets to help patients understand their health conditions and local health services. All patients referred to hospital under the urgent, two-week wait referral system were given a leaflet to help them understand why they had been referred.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services. The practice involved social care organisations in care planning for these patients.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 35 patients as carers (1.8% of the practice list). They asked all new patients to identify whether they were a carer. Staff told us that because the practice was small, they had a good knowledge of patients and knew when the carer's register needed updating. Staff told us that they recognised changes in patients' circumstances and alerted clinicians if they felt that they needed further support or assessment. Written information was available to direct carers to the various avenues of support available to them and all carers were invited for a 'flu vaccination.

Staff told us that if families had experienced bereavement, their usual GP often contacted them and the practice sent them a sympathy card and a pack of support information. This call was followed by the offer of a patient consultation at a flexible time and location to meet the family's needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Saturday morning from 9am to 12noon, once a month, for working patients who could not attend during normal opening hours. At the time of our inspection, they were engaged in looking at providing further extended hours appointments in association with other local practices. The practice nurse provided patient appointments until 6pm on a Tuesday and the GP would offer a late appointment for a patient on the basis of individual need. Patients were encouraged to book appointments online.
- There were longer appointments available for patients with a learning disability, for those with complex needs and patients needing translation services.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice gave a dedicated telephone number to the local A&E department and nursing home for urgent communications.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- A phlebotomist visited the practice one morning and one afternoon each week to take patient bloods.
- A midwife provided antenatal clinics every week and clinics for baby vaccinations and immunisations were held every other week. The practice was flexible with appointments for baby vaccinations and offered them outside clinic times for those who could not attend.
- There were several other services available in the building including podiatry, a community eye care service, a hearing aid clinic and a physiotherapy service.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- All practice patient services were on the ground floor. There was a ramp both outside and inside the building to aid access and the reception counter was lowered in one area. The building also had a lift to aid patients attending services on the upper floor.
- The practice provided a point-of-care anticoagulation service for patients in the local area, including practice patients. This service assessed levels of blood clotting for patients who were taking certain medications and patients' medication doses were adjusted by the GP accordingly.
- The practice always tried to find time for a GP appointment, if requested, for elderly patients who were attending the premises for other services, to save an additional journey to the surgery.
- Other reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services. The practice had discontinued taking requests for patient prescriptions over the telephone but had allowed very elderly and vulnerable patients to continue to use this service.
- There was a dedicated room in the practice for breastfeeding mothers.
- The practice had considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- Staff sent letters to new mothers enclosing a new registration form for the baby and giving them details of the baby's vaccination and immunisation programme and health checks.
- At the time of inspection, the practice was working on being able to provide a one-stop clinic for diabetic patients with input from the podiatry service, the GP and the practice nurse.

Access to the service

The practice doors opened from Monday to Friday from 8.30am to 6pm and telephone access to the practice started at 8am and finished at 6.30pm. Appointments were offered from 9.20am to 11.45am and from 3.30pm to 5.25pm on all weekdays except Thursday, and from 9.30am

Good

Are services responsive to people's needs?

(for example, to feedback?)

to 11.45am on Thursday. There is a rota for the three GP practices in the Medical Centre to cover any patient emergency appointments, including home visits, on a Thursday afternoon. The practice also offered extended hours appointments on one Saturday each month from 9am to 12noon. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments and telephone appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was, with one exception, higher than local and national averages.

- 83% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 94% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 73%.
- 78% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 85%.
- 96% of patients said their last appointment was convenient compared with the CCG average of 93% and the national average of 92%.
- 89% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.
- 64% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 63% and the national average of 58%.

Patients told us that they were able to get appointments when they needed them. Four patient comment cards mentioned difficulties with getting an appointment and two patient comment cards said that the telephone appointments with the GP were good. We saw that the next routine patient appointment with the GP was in four working days.

The practice had a system to assess:

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

Staff added an alert to the patient computer record for those patients who were recognised as needing priority treatment. Staff asked patients or their family/carer for details of the need for a visit and recorded the request for the GP. If they felt that the visit could be urgent, they interrupted the GP surgery to ask for advice. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits and had a good knowledge of patient conditions needing urgent care. The practice had protocols for dealing with patient emergency situations.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The head receptionist was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a poster displayed on the noticeboard in the patient waiting area and information available on the practice website.

We looked at one written complaint received in the last 12 months and found it had been dealt with with openness and honesty. Lessons were learned from the complaint and these lessons were shared with staff at a practice meeting. Staff showed us a book used to record verbal complaints but this book had ceased to be used in 2014. We were told that the practice received very few complaints and that verbal complaints were always resolved at the time. The practice said that they would start to use the book again so that there could be better analysis of trends. Lessons learned following the one patient complaint that we reviewed resulted in better management of the complaint-handling procedure and better administrative processes associated with patient non-attendances for appointments.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a mission statement which was: "Our aim is to provide the highest quality of care by placing the welfare of our patients at the heart of everything we do." Staff knew and understood the values.
- The practice displayed the practice charter that set out the practice mission statement and obligations to its patients on the noticeboard in the patient waiting area.
- The senior full-time GP partner retired in December 2016 and the part-time GP partner became the full-time GP service provider. The practice was planning to develop a business strategy plan following the changes that it had experienced with practice staff and the move to the new premises.

Governance arrangements

The practice generally had comprehensive systems in place to support the delivery of the patient charter and good quality care. These outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. The principal GP was the practice safeguarding lead and the practice nurse was the infection prevention and control lead.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Safety assessments associated with the building structure were in place and up to date. Equipment used to deal with patient medical emergencies was checked to ensure it was safe to use and was in good working order, although the practice had not had sight of these checks before our inspection and so had not assured themselves that they had been carried out.
- We saw evidence of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Actions taken as a result of these were reviewed to ensure that they were effective.
- We found that staff training was timely and comprehensive although the overview of this training was not complete and there was no formal programme in place for every aspect of mandatory staff training.

Leadership and culture

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

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

- The practice gave affected people reasonable support, truthful information and a verbal or written apology.
- Following our visit the practice intended to recommence recording verbal complaints.

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

- The practice held and documented a monthly multi-disciplinary meeting with community health staff and other health and social care services to monitor vulnerable patients. The practice nurse held a

Are services well-led?

Good

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

pre-arranged telephone conference monthly with the health visitor to monitor vulnerable families and discuss safeguarding concerns. There was good communication for these patients between staff and health visitors.

- Staff told us the practice held regular team meetings. There was a clinical meeting once a month for all GPs and nurses in the Medical Centre. The principal GP planned to extend these meetings to just GPs in order to offer and receive peer support in the management of patients.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view both on the practice computer system and also in paper copy in the reception office.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff turnover was low and some staff members had been in post for over 10 years.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients, through the patient participation group (PPG) and through patient surveys. The PPG met three times a year, were consulted on patient surveys and submitted proposals for improvements to the practice management team. For example, the practice made improvements to parking arrangements for disabled patients following patient feedback and improved patient confidentiality in the reception area.
- The NHS Friends and Family test, complaints and compliments received.
- Staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had improved the security of prescriptions at the suggestion of a member of staff and also introduced a system that required pharmacy prescription collection staff to sign for prescriptions. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and worked with the local clinical commissioning group (CCG) to improve outcomes for patients in the area. The practice GP was on the CCG board and attended CCG board meetings. At the time of the inspection, work was underway to look at practice provision of some patient services, such as diabetic care, for patients in the local area who were on other practice lists. Also work was taking place on the forming of a federation of local practices and provision of extended hours appointments.