Canterbury Health Centre

Quality Report

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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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Canterbury Health Centre on 20 October 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients 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.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw areas of outstanding practice:

- There was an exemplary approach to reporting and learning from significant events and the volume of reported events was very high. Learning from the practice was discussed amongst local GPs during training events.

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 report incidents and near misses. There was an exemplary approach to reporting and learning from significant events and the volume of reported events was very high.
- Medical alerts were acted on quickly and effectively.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice used every opportunity to learn from incidents, to support improvement. Learning was based on a thorough analysis and investigation.
- Information about safety was highly valued and was used to promote learning and improvement.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. The practice performance was had been consistenly higher than the local and national averages over the last three years.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement. There were non clinical audits that supported effective treatment.
- The practice participated in a community hub operating centre (CHOC) pilot aimed at improving communication between health and social care services
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey showed patients rated the practice higher than others for almost all aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- When dealing with safeguarding incidents the practice routinely gave specific attention to the impact the issues might have had on any carers involved.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients 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 easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- 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.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There was clear succession planning.

Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems for managing notifiable safety incidents and ensured this information was shared with staff to help ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong 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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- There was an anti coagulation service (anti coagulation is the use of thinning agents/medicines to prevent blot clots, which requires regular monitoring through blood tests) that visited patients in their own homes if needed.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Good

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

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was better than the clinical commissioning group (CCG) and/ national average. For example the percentage of patients on the diabetes register, with a record of a foot examination and a risk classification within the proceeding twelve months had been consistently higher than local and national averages since 2005 and currently was 92% compared to a national average of 89%. The practice had outperformed the national average by between 1% and 11% every year over the last ten years
- Longer appointments and home visits were available when needed. This included, learning disability, mental health and patients with dementia as well as those who needed translation services or homeless patients.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

Summary of findings

- 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 relatively high for all standard childhood immunisations.
- We saw that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG and national average of 83%.
- The practice offers a full contraceptive service including long-acting reversible contraceptives such as the fitting of an intrauterine device. (A device inserted into the womb to prevent pregnancy). This service was offered to their own and other practices' patients.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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 those with a learning disability. Homeless patients were able to register with the practice using the practice's address or the address of a local homelessness support organisation.
- The practice offered longer appointments for patients with a learning disability.

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- When dealing with safeguarding incidents the practice routinely gave specific attention to the impact the issues might have had on any carers involved.

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).

- Eighty two per cent of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months for which figures were available (to March 2015), which is comparable to the national average.
- Ninety per cent of patients diagnosed with a mental health disease had a care plan during the last 12 months. This was better than the CCG at 83% and the national average at 88%. The practice had outperformed the national average and local average every year for the last four years.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published July 2016. The results showed the practice was performing better than local and national averages. Two hundred and ninety seven survey forms were distributed and 103 were returned. This represented two percent of the practice's patient list.

- 96% found it easy to get through to the practice by phone compared with the clinical commissioning group (CCG) average of 80% and the national average of 73%.
- 85% were able to get an appointment to see or speak with someone the last time they tried compared with the CCG average of 88% and the national average of 85%.
- 88% described their overall experience of the practice as good compared to the CCG average of 82% and the national average of 73%.
- 88% 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 89% and the national average of 85%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards all bar one of which were positive about the standard of care received. The themes that ran through the responses were that the practice was caring and compassionate but also efficiently run. The one negative comment related to an individual rather than an organisational issue.

We spoke with three patients during the inspection. All patients said they were satisfied with the care they received and support the themes from the comment cards.

Outstanding practice

- There was an exemplary approach to reporting and learning from significant events and the volume of reported events was very high. Learning from the practice was discussed amongst local GPs during training events.

Canterbury Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Canterbury Health Centre

The Canterbury Health Centre is a GP practice located in the City of Canterbury, Kent. It provides care for approximately 5250 patients. It is located within the city boundary and has a mainly urban patient population.

There are two male GP partners. There is one salaried female GP. There are two nurses and two healthcare assistant all female. There is a practice manager and administrative and reception staff.

The demographics of the population the practice serves is different to the national averages in that it is much younger. The number of patients between 15 and 24 years of age is approximately twice the national average and there are more patients between the ages of 25 and 30 that the national average. The number of patients in age ranges from 40 to 79 is less that that nationally sometimes markedly so. The number of patients aged 80 years and over is similar to the national average.

The majority of the patients describe themselves as white British. Income deprivation and unemployment are in line with national averages. Although the practice as a whole is not in an area of deprivation there are pockets of urban deprivation within it.

The practice has a general medical services contract with NHS England for delivering primary care services to local communities. The practice offers a full range of primary medical services. The practice is a training practice.

The practice is open between 8am and 6.30pm Monday to Friday. There are evening surgeries on Mondays and Wednesdays until 7.45pm and 7.30pm respectively. Appointments were determined by individual GPs and patients might be seen at any time that the practice was open.

The surgery is purpose built with consulting, treatment rooms and administration rooms on the ground floor. There is access for disabled patients as well as mothers and babies.

Services are provided from

Canterbury Health Centre

26 Old Dover Road

Canterbury

CT1 3JH

The practice has opted out of providing out-of-hours services to their own patients. This is provided by Integrated Care 24. There is information, on the practice building and website, for patients on how to access the out of hours service when the practice is closed.

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

Detailed findings

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 20 October 2016. During our visit we:

- Spoke with a range of staff, including a senior partner, a nurse, healthcare assistants, administrators and receptionists. We spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and on the telephone.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

- There was a very open culture in respect of reporting incidents which were seen as learning opportunities.

There was an effective 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.
- There were comprehensive systems to keep patients safe. For example national patient safety alerts were dealt with by the practice manager and there was a system to help ensure they were dealt with if received when the practice manager was absent. They were sent on to the GPs and nurses for clinical matters and other staff as necessary. We looked at two recent alerts and saw that they had been dealt with in accordance with the instructions within the alert. Alerts were discussed at clinical meetings.
- The practice showed us a medicines alert. It had been sent out three days previously. During that time the practice had received the alert, searched the records and identified the one patient to whom the alert was relevant. It had contacted the patient an appointment had been made for a review.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice.

- There was evidence that the whole team were engaged in reporting,reviewing and improving safety as reports came from all areas of the practice. There had been reports concerning, prescribing, administration, record keeping, clinical issues, referrals, district nursing, information governance, medical equipment and unexpected deaths. There had been 38 reports during the previous 12 months.
- We saw reports had been discussed at practice meetings by all staff and had resulted in changes. For example some changes had been suggested by administrative staff such as the manner in which prescriptions were processed. Other changes had been suggested by clinical staff such as the protocol for dealing with patients who presented as very unwell at the reception.
- There was no formal evidence that the learning from these incidents was formally shared with other practices. However we were told that the learning was discussed amongst local GPs during training events.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse, which included:

- There were arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding and staff knew who this was. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3.
- We looked at two anonymised reported safeguarding incidents. They showed that staff looked more widely that the traditional safeguarding agenda and considered possible financial and emotional abuse. When discussing safeguarding incidents the practice routinely gave specific attention to the impact the issues might have had on any carers involved.
- A notice in the waiting room advised patients that chaperones were available if required. Only nurses and healthcare assistants were used as chaperones, all had

been 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. The premises were clean and tidy. A practice nurse was the infection control clinical lead, they liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol and staff had received up to date training. Annual infection control audits were undertaken. Changes as a result of audits and training included; standardisation of personal protective equipment across the different clinical rooms, an upgrade to the spillage kits and a new pillow for use when taking patients' blood.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to help ensure prescribing was in line with best practice guidelines for safe prescribing. The practice's prescribing records showed that they were in line other practices with a similar patient population
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Printer drawers, containing blank prescriptions, were locked. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed two personnel files and found 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. We reviewed the recruitment file of a potential new employee and saw that it contained information required by the regulations and complied with the practice's own policy.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to help ensure the equipment was safe to use and clinical equipment was checked to help ensure it was working properly. 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 were for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system for all the different staffing groups to help ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was a first aid kit and an accident book.
- 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 system for recording the "use by" dates of medicines and staff were notified when this date was near. We saw, for example, staff had re-ordered two emergencies medicines because they knew there was a long waiting time for them and they had been notified that they were due to expire next month.
- 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

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems 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. We saw that NICE and other guidance was discussed at clinical meetings.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. For example there had been an audit of the use of NICE guideline 69, respiratory tract infections and antibiotic prescribing. This had led to clinical discussions reinforcing the use of the guidelines. An example of national best practice was provided by the use of the Cardiff health check for patients with learning disability.

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 showed the practice achieved 98% of the total number of points available, with 6% exception reporting. (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.

- Performance for diabetes related indicators was better than the clinical commissioning group (CCG) and/ national average. For example the percentage of patients on the diabetes register, with a record of a foot examination and a risk classification within the proceeding twelve months had been consistently higher than local and national averages since 2005 and currently was 92% compared to a national average of 89%. The practice had outperformed the national average by between 1% and 11% every year over the last ten years
- The percentage of patients with chronic obstructive pulmonary disease (COPD - a long term respiratory condition) having an annual check by a healthcare professional was 92%. This was better than the CCG at 88% and the national average at 90%. The practice had outperformed the national average and local average every year for the last three years.
- Performance for mental health related indicators was marginally better than the CCG and national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate was 91%. This was better than the CCG at 90% and the national average at 88%.

There was evidence of quality improvement including clinical audit.

- There had been over ten clinical audits completed in the last two years, six of these were completed audits, of two cycles or more where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, and peer review.
- Findings were used by the practice to improve services. For example, recent action taken as a result included a more structured approach to the taking and recording of consent forms for some minor procedures. A second audit showed an improvement in the quantitative and qualitative data.
- There were audits of administrative processes such as an audit of the practice's system for ensuring that patients who had been referred for rapid access, for cancer referrals, were seen within the two week time frame.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Good

Are services effective?

(for example, treatment is effective)

- 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. A GP and a practice nurse were the leads for diabetes. Both had recently been on a diabetes update course. They had been trained in insulin initiation.
- 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. On the day of the inspection the practice nurse was attending update training for the administration of vaccines.
- 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. For example, the practice hosted quarterly clinical supervision sessions, led by the practice nurse, for the nurses and healthcare assistants so that nurses from other practices could also take part and share learning. All staff had received an appraisal within the last 12 months. Staff spoke highly of the practice's support for training. There were examples of administration staff supported to become healthcare assistants. The practice had taken on a school leaver under the apprentice scheme who had subsequently been employed at the practice.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice was committed to working collaboratively. Patients who had complex needs were supported to receive coordinated care and there were innovative and efficient ways to help deliver joined-up care to vulnerable patients. For example the practice participated in community hub operating centres pilot aimed at improving communication between health and social care 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. It had proved difficult to sustain formal multi-disciplinary meetings and the practice was seeking to promote the use of video conferencing as a means of making these meetings effective.

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Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- 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.
- The process for seeking consent was monitored through patient records audits. There had been an audit of consent to a particular procedure the results of which had been used to promote better practice.

Supporting patients to live healthier lives

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

Good

Are services effective?

(for example, treatment is effective)

There had been an audit to identify patients who were, or might be pre-diabetic. Those whose blood sugar reading showed that they might be at risk of developing diabetes were offered a face to face consultation with either the practice nurse or a GP.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 83%% and the national average of 83%. There was a policy to contact by telephone patients who did not attend to remind them of their cervical screening test. The practice encouraged uptake of the screening programme by using information in different languages and easy read for those with a learning disability. They ensured a female sample taker was available. There were systems to help 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.

The practice also encouraged its patients to participate in national screening programmes for bowel and breast cancer screening. For example, 70% of women aged between 50 and 70 had attended screening for breast cancer which was lower, but not significantly so, than both the CCG and national average of 72%. Bowel cancer screening was similar to local and national averages, for example at 56% compared with the CCG average of 60%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 92%, national averages being from 73% to 93% and for five year olds from 71% to 93%, national averages being from 81% to 95%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We saw 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.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The reception area serviced patients from another GP practice, a dentist and a podiatry provider. Conversations between receptionists and patients could be overheard in the patient waiting area. The receptionists were aware of patient confidentiality and we saw that they took account of this in their dealings with patients. There was a private area if patients wished to discuss sensitive issues or appeared distressed.

All of the 21 patient Care Quality Commission comment cards we received were positive about the service experienced, there was one negative comment, however it was about an individual issue. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

There was a virtual patient participation group (PPG) and we spoke with three members. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards 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 results were, almost always, above average for satisfaction on consultations with GPs and nurses. For example;

- 94% said the GP was good at listening to them compared to the CCG average of 91% and national average of 86%. When asked the same question about nursing staff the results were 96% compared to the CCG average of 93% and national average of 91%.
- 92% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%. When asked the same question about nursing staff the results were 94% compared to the CCG average of 95% and national average of 92%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%. When asked the same question about nursing staff the results were 98% compared to the CCG average of 98% and national average of 97%.
- 89% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%. When asked the same question about nursing staff the results were 98% compared to the CCG average of 97% and national average of 97%.
- 89% said they found the receptionists at the practice helpful compared to the CCG average of 90% and 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. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the National GP Patient Survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were better than local and national averages;

- 94% said the GP was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%. When asked the same question about nursing staff the results were 90% compared to the CCG average of 92% and national average of 90%.
- 88% said the GP was good at involving them in decisions compared to the CCG average of 85% and

national average of 82%. When asked the same question about nursing staff the results were 91% compared to the CCG average of 87% and national average of 85%.

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

- There were translation services available.
- Information leaflets were available in easy read format.

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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 50 patients as carers, approximately 1 percent of the patient list. The practice recently reviewed the new patient registration form to more effectively capture details of patients who were or who had carers. The practice was in the final stages of recruiting a carers champion, a former member of staff with extensive experience in the field of caring.

Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP normally telephoned them and would visit the family at home if the family needed this. They were provided advice on how to contact support services. Palliative care was a standing agenda item in the practice two weekly meetings. They had a palliative care register and used a spreadsheet to aid discussions, the practice were considering ways to improve the spreadsheet by including information about preferred place of death, hospice involved and do not resuscitate instructions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example the practice provided anticoagulant monitoring for the locality. They prescribed the anticoagulants for all the patients they monitored. Anticoagulants are thinning agents/medicines to prevent blot clots, which requires regular monitoring through blood tests.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The anticoagulation clinic included home visits for those who were housebound or infirm.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Homeless patients were able to register with the practice using the practice's address or the address of a local homelessness support organisation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were offered at the following times on Mondays and Wednesdays until 7.30pm and 7.45pm respectively. Appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Appointments were determined by individual GPs and patients might be seen at any time that the practice was open.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 96% of patients were satisfied with the practice's opening hours compared to the CCG average of 80% and the national average of 73%.
- 85% of patients said they could get through easily to the practice by phone compared to the CCG average of 79% and the national average of 86%.

The practice had a system to assess:

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

There was a duty doctor who called patients who were seeking a home visit to assess the urgency and explore alternatives to a home visit. 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.

Listening and learning from concerns and complaints

- The practice had an effective system for handling complaints and concerns.
- Its complaints policy and procedures were in line with recognised guidance.
- There 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 for instance in the practice leaflet.

We looked at the five complaints that had been received in the last 12 months, three were formal complaints, and two other cases had been resolved informally. The complainants had received timely, comprehensive and forthright replies to the issues raised. Lessons were learnt from individual concerns and complaints. We saw that the complaints were broken down into categories such as clinical, administrative and prescribing and that this was used to drive improvement. For example one complaint was also a significant event. We saw that the lessons learned from it included making changes to clinical practice as well as individual learning about managing patients' expectations.

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 contained within the practice's statement of purpose. Providing the best quality care was at the centre of the statement and all the staff we spoke with knew and were committed to this.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. There was clear and structured succession planning with partners, managers and staff clear on how the changes would be managed.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- There were practice specific policies that were available to all staff. These had undergone a thorough review over the last two years. The was a scheme to review the policies after specific time periods or when external changes made them redundant.
- The practice had a comprehensive understanding of its own performance.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice was a training practice and, as such, the quality of its governance was regularly reviewed as part of the accreditation to train.

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.
- There was an exemplary level of reporting of incidents, staff were encouraged to view them not as incidents which might lead to staff being reprimanded, but as opportunities for learning. Thirty eight "learning events" had been reported over the last year, they had been discussed at staff meetings, and changes implemented to reduce the chances of similar incidents happening again.
- There was a very open culture in respect of reporting incidents and there were effective system to help ensure the learning was shared at all levels from partners to apprenticed staff. The number of reported incidents was exceptional for a practice of this size.
- The practice had taken the lead in drawing up a revised contract for the delivery of anticoagulation services by GPs after it had initially raised concerns about the workability of the original.
- The practice had systems to help ensure that when things went wrong with care and treatment. The practice gave affected people reasonable support, truthful information and a verbal and written apology. The practice kept written records of verbal interactions as well as written correspondence.
- The leadership structure was clear and staff felt supported by management. Staff told us the practice meetings were open, forthright and an effective means of communication. There was a practice meeting every other week. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff us told of social events that involved the whole team.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Good

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

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.

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

- The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.
- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was a large virtual PPG. The practice had tried to generate interest in physical PPG meetings, for example by asking members what times might be convenient and varying the meeting times. This had not generated the hoped for interest and an electronic/virtual group had evolved from this. The group had made suggestions which the practice had acted on. For example there had been a shift to a greater number of afternoon appointments as a result of suggestions and patient surveys.
- The practice had gathered feedback from 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. For example some staff, who also working in neighbouring practices, wanted to change their working arrangements. The practice had facilitated this, even though it meant contacting another practice and making substantial changes to appointment rotas for both practices. 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 part of local pilot schemes to improve outcomes for patients in the area. For example The practice was a provider of anticoagulant monitoring for the locality, that is for patients from other practices as well as their own. They also prescribe the anticoagulants for all the patients they monitor.
- The practice was a training practice and all the staff were to some degree involved in the training of future GPs. The clinical knowledge and decision making of GPs and nurses was under constant review though the need to act as a mentor to trainees. The practice showed that it wished to learn as much from trainees as to teach them. The practice hosted quarterly clinical supervision sessions, led by the practice nurse, for nurses and healthcare assistants so that nurses from other practices could also take part and share learning.
- The practice was involved in apprenticeship programs and staff, who had come as apprentices had remained as full time staff. Other examples included members of staff who had joined the practice as receptionists and gone on, with the support of the practice, to become healthcare assistants.