Dr Boteju and Partners

Quality Report

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Date of inspection visit: 18 January 2018
Date of publication: This is auto-populated when the report is published

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

This practice is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Dr Boteju and Partners on 18 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. Patients' needs were assessed using clinical templates that had been formulated by the lead GP using best practice guidance such asthose provided by The National Institute for Health and Care Excellence (NICE) and locally by the clinical commissioning group (CCG). We found that these templates aided appropriate monitoring of treatment and care provision.
- A programme of clinical audit was in place that demonstrated quality improvement.
- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. However we found that some processes related to employment checks and record keeping of identified risks needed improvement.
- GP patient survey results indicated patients were positive about the care received, practice opening times, the ability to get an appointment and the ease of being seen on time. However it also noted dissatisfaction in relation to getting through to the practice by phone and with the experience of making an appointment.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

Summary of findings

- Performance for antibiotic items prescribed, that could be used when others had failed, as a percentage of similar antibiotics prescribed, were lower than average compared against the local CCG and national averages. This was in line with national guidance of using these medicines sparingly, to avoid drug-resistant bacteria developing.
- Staff had lead roles within the practice with a strong focus on patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Feedback from patients we spoke with and from the CQC comments cards was positive regarding the care received at the practice.

The areas where the provider **should** make improvements are:

- Complete the review of the immunisation status of clinical and non clinical staff and ensure a documented process to evidence compliance.
- Develop a more formal approach to employment checks and staff induction.
- Continue to monitor and ensure improvement to national GP patient survey results, and improve patient experience of getting through to the practice by phone and with making an appointment.
- Improve record keeping of identified risks, for example control of substances hazardous to health (COSHH).

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

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Complete the review of the immunisation status of clinical and non clinical staff and ensure a documented process to evidence compliance.
- Develop a more formal approach to employment checks and staff induction.
- Continue to monitor and ensure improvement to national GP patient survey results, and improve patient experience of getting through to the practice by phone and with making an appointment.
- Improve record keeping of identified risks, for example control of substances hazardous to health (COSHH).

Dr Boteju and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Boteju and Partners

Dr Boteju and Partners also known as Woodview Medical Centre situated at Holmcross Road, Thorplands, Northampton, Northamptonshire is a GP practice which provides primary medical care for approximately 9,890 patients living in the Northampton East and South area. There is moderate level of deprivation in the area mainly relating to low income.

Dr Boteju and Partners provide primary care services to local communities under a General Medical Services (GMS) contract, which is a nationally agreed contract between general practices and NHS England. The practice population is predominantly white British along with a small ethnic population of Asian, Afro Caribbean, mixed race and Eastern European origin.

The practice currently has three GPs partners and two salaried GPs (all males). There are two GP trainees (both females) and one male medical graduate currently undergoing a placement in primary care. There are two nurse prescribers two practice nurses and two specialist nurses (diabetes and mental health) who are supported by a health care assistant. There is practice manager who is supported a team of administrative and reception staff. The local NHS trust provides health visiting and community nursing services to patients at this practice.

There is a car park outside the surgery with adequate disabled parking available.

The practice is open between 8am and 6.30pm Monday to Friday. The practice is also open during the second Saturday morning of each month between 8.30 and 12 noon for pre-booked appointments only.

When the practice is closed services are provided by Integrated Care 24 Limited via 111.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a number of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We looked at five staff files to verify the arrangements for staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (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). However the practice had not carried out a DBS check for a clinical staff member that had moved from a similar role in another GP practice. The practice manager told us that as the roles were similar and as they had checked the DBS risk assessment held by the previous practice, and had cross checked with a more recent DBS check, they had concluded a further DBS was not needed. After our inspection the practice confirmed that an enhanced DBS check had now been made on this staff member with no risks identified. We noted that two of the five files did not contain a CV (curriculum vitae). After our inspection the practice manager confirmed that these had been traced and added to the concerned staff files.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. For example we saw that the practice had liaised with the local authority and the housing department to ensure the safety of an older person who had been homeless.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- We reviewed the standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Hand wash facilities, including soap dispensers were available throughout the practice. There were cleaning schedules and monitoring systems in place. There was an infection prevention and control (IPC) lead who liaised with the local infection prevention teams to keep up to date with best practice. We saw that all applicable staff had been checked for their immunisation status related Hepatitis B. However at the time of our inspection the practice was in conjunction with the occupational health services at Northampton General Hospital was in the process of completing the immunisation status of applicable clinical and non clinical staff in relation to other immunisations recommended by the Health and Safety at Work Act 1974.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. This included the planning of annual leave and unplanned absence. The practice operated a skill mix system based on clinical needs and used a variety of staff including GPs advanced nurse practitioners specialist mental health nurse and health care assistant to provide care.
- There was an effective induction system for substantive and temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. This included the reception staff. We saw that systems were in place to refer and manage patients with severe infections, for example, sepsis (a life-threatening illness caused by the body's response to

an infection). The practice had introduced templates to diagnose the condition so appropriate care could be accessed quickly as recommended by the National Institute for Health Care and Excellence.

- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The practice used templates developed by the lead GP to manage and deliver safe care and treatment. We were shown templates related to mental health, suicide prevention and sepsis and found these comprehensive and in accordance with the current best practice guidance. The care records we reviewed showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There were regular multi-disciplinary team (MDT) meetings. There was a process to communicate with the district nursing team as they currently did not attend the MDT meetings. The pathology service was able to share patient clinical information and results electronically. There was a system to review patients that had accessed NHS 111 service and those that had attended the A&E department for emergency care.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- The practices used dedicated computer software to manage prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship (which aims to improve the safety and quality of patient care by changing the way antimicrobials are prescribed so it helps slow the emergence of resistance to antimicrobials thus ensuring antimicrobials remain an effective treatment for infection). The practice held regular meetings with the CCG pharmacist to ensure their prescribing patterns met the CCG good practice guidance. The practice was not an outlier in any prescribing area.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines including those receiving high risk medicines. The IT & Data Quality Manager ensured such patients were recalled for their check at the appropriate intervals. We checked several records of patients that received high risk medicines and found that they had been followed up appropriately.

Track record on safety

The practice had a good safety record.

- There were risk assessments in relation to safety issues. For example for electrical safety of equipment used within the practice, infection control, legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and control of substances hazardous to health (COSHH). COSHH risk assessments and the related safety sheets were available for the cleaning products used by cleaners. However the practice could not provide us with such information for the other commonly used cleaning materials such as hand wash and related products. After our inspection, the practice confirmed that the COSHH risk assessments and the related safety sheets were now available.
- There was a system for receiving and acting on safety alerts. Alerts were received by the practice manager and disseminated to the appropriate staff for action. We noted appropriate actions were taken following receipt of alerts. For example we reviewed a patient safety alert related to a medicine used to treat epilepsy and bipolar disorder and occasionally used to treat migraine or

chronic pain. We found that the practice had acted on the recommendations and ensured young adults and women of childbearing potential were prescribed this medicine with caution.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Staff we spoke with understood their duty to raise concerns and report incidents.

There were systems for reviewing and investigating when things went wrong. There had been six significant events recorded in the last 12 months. The practice learned and shared lessons identified themes and took action to improve safety in the practice. For example, following an immunisation incident related to a child the practice had changed the way immunisations were administered and ensured staff were made aware of the changed process including through a clinical meeting.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Patients' needs were assessed using clinical templates that had been formulated by the lead GP using best practice guidance s such asthose provided by The National Institute for Health and Care Excellence (NICE) and locally by the CCG.
- Performance for antibiotic items prescribed that are cephalosporins or quinolones (2%) as a percentage of broad class of similar antibiotics prescribed were lower than average compared against CCG (4%) and national (5%) averages.Cephalosporins and quinolones are antibiotics that can be used when others have failed. It is important that they are used sparingly, to avoid drug-resistant bacteria developing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used specific computer software to identify and monitor patients whose medicine management was shared with others, for example a consultant in an acute hospital.Such patients were identified through a monthly search and monitored appropriately.
- Staff advised patients what to do if their condition got worse and where to seek further help and support. For example the practice had reviewed patients who were prescribed a medicine to reduce the risk of heart disease and stroke and had either changed their medicine to reduce its side effects of interaction with other medicines or had advised the patients to be aware of the potential side effects.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of their medicines.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Since April 2017 the practice had carried out 78 health checks.
- The practice had a process to identify patients at risk of dementia. Patients diagnosed with dementia were offered annual reviews with non-attenders followed up.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Nurses supported by GPs who were responsible for reviews of patients with long term conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), high blood pressure (hypertension) and mental health had received specific training.
- The practice used templates based on good practice guidance to manage people with long term conditions.
- There was a system to identify patients at risk of hospital admission that had attended A&E or the out of hours service and these patients were regularly reviewed to help them manage their condition at home.
- The practice had a system to monitor patients that received long term medicines.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90% set nationally.
- 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.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Good

Are services effective?

(for example, treatment is effective)

Working age people (including those recently retired and students:

- The practice's uptake for cervical screening was 70% compared with the CCG average of 71% and the national average of 72%, which was below the 80% coverage target for the national screening programme. The practice were aware of the need to improve. Sample-takers received initial training and updating every three years, and the practice offered appointments at different times throughout the week with a written reminder to encourage attendance.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The practice undertook 241 health checks in the preceding 12 month period. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- 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 worked closely with social care colleagues and updated care plans of vulnerable patients accordingly to keep them safe. Vulnerable patients were provided with a list of telephone numbers for support.
- The practice had identified patients who were severe/ moderately frail. These patients were offered annual reviews with emphasis on falls prevention and medication reviews. All such patients were encouraged to consent to an enriched summary care record which contained further information from the GP record, in addition to medication, allergies, and adverse reactions, to support the delivery of person centred co-ordinated care.

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

- A practice funded mental health nurse provided care and support for this population group.
- 71% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average.
- 90% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 92% compared with the CCG average of 94% and the national average of 91%; and the percentage of patients experiencing poor mental health who whose notes record their smoking status was 92%; compared with the CCG average of 95% and the national average of 95%.
- The practice had a computerised system which took account of CCG and national guidance for the monitoring of repeat prescribing for patients receiving medicines for mental health needs.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

The most recent published Quality Outcome Framework (QOF) results were 98% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96. The overall exception reporting rate was 9% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

The exception reporting rate for the following clinical indicators were higher than CCG and national averages:

- Mental health: Practice 26% compared with the CCG average of 14 and the national average of 11%
- Osteoporosis: Practice 40% compared with the CCG and national average of 14%

We reviewed the exception reporting and found that the practice had made every effort to ensure appropriate decision making including prompting patients to attend for

Good

Are services effective?

(for example, treatment is effective)

the relevant monitoring and checks. Discussions with the lead GP showed that procedures were in place for exception reporting as per the QOF guidance and patients were reminded to attend three times and had been contacted by telephone before being subject of exception. They also told us that the practice was situated in a deprivation area which sometimes affected patient attendance at health reviews.

- The practice was actively involved in quality improvement activity and a programme of a clinical audit was in place. For example a repeat audit of patients who received treatment for attention deficit hyperactivity disorder (ADHD) had showed an improvement in the number of patients attending the required three monthly monitoring from the initial 53% to 75%.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Appropriate records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with on-going support. Staff we spoke with described an induction process but we did not see documentary evidence of this induction. Other ongoing support included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by regular debrief and periodic appraisal of clinical decision making, including non-medical prescribing.
- There was a system for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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. Regular meetings took place with other primary health care professionals when care plans were routinely reviewed and updated as needed.
- The pathology service were able to share patient clinical information and results electronically.
- There was a system to review patients that had accessed NHS 111 service and those that had attended the A&E department for emergency care.
- There was an information sharing system to review patients attending for Urgent Care provided by Integrated Care 24 Limited.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Patients could access the wellbeing service (mental health) hosted by the local NHS trust on site as well as the dedicated mental health nurse provided by the practice.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

Good

Are services effective?

(for example, treatment is effective)

- The practice supported national priorities and initiatives to improve the population's health, for example, health promotion programmes such as smoking, coronary heart disease, blood pressure and hypertension, and family planning.
- A dedicated diabetic nurse provided lifestyle advice for the pre and diabetic patients.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.
- All of the 17 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients commented that their experience of the care received was positive and the practice staff had been helpful friendly caring and treated them with dignity and respect. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. There were 302 surveys sent out and 103 were returned. This represented about 1% of the practice population. The practice was comparable with other practices in the local area for its satisfaction scores on consultations with GPs and nurses. For example:

- 80% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 78% of patients who responded said the GP gave them enough time; CCG 85%; national average 86%.
- 89% of patients who responded said they had confidence and trust in the last GP they saw; CCG 95%; national average 96%.
- 78% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG 83%; national average 86%.
- 86% of patients who responded said the nurse was good at listening to them; CCG 90%; national average 91%.
- 89% of patients who responded said the nurse gave them enough time; CCG 91%; national average 92%.
- 95% of patients who responded said they had confidence and trust in the last nurse they saw; CCG 97%; national average 97%.
- 86% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG 89%; national average 91%.
- 82% of patients who responded said they found the receptionists at the practice helpful; CCG 85%; national average 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids such as signage were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice was in the implantation phase of the CCG care navigation project which aimed to navigate patients to other services available within the CCG area, for example services offered by social care as well as by the local community health trust.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 115 patients as carers which equated to 1% of the practice list. The practice had identified a carer's champion who provided information and directed carers to the various avenues of support available to them. The practice had a carers board

Good

Are services caring?

and new carers were invited to complete a carer registration form and were provided with written information, including referral to Northamptonshire Carers where appropriate about support available to them. Carers were offered flu and other vaccinations as appropriate. The practice achieved the bronze level investors in carers standard (awarded by the county council, the NHS and Northamptonshire Carers) which recognised efforts made by GP practices in the identification of and support available to carers.

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- Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Results from the national GP patient survey to questions about their involvement in planning and making decisions about their care and treatment were comparable with local and national averages:

- 75% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 84% and the national average of 86%.
- 71% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG 79%; national average 82%.
- 86% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG 88%; national average 90%.
- 76% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG 83%; national average 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. The practice was open Monday to Friday from 8am until 6.30pm. Pre bookable appointments were available every second Saturday of the month from 8.30 until 12 noon. Patients could access on line services such as advanced booking of appointments and repeat prescription requests. The practice website had a page on self-care which gave advice on self-care for common ailments.
- The practice improved services where possible in response to unmet needs. For example the GPs were involved in the management of patients with a long term condition that caused pain all over the body with a specific targeted medicine management programme.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. There was sensor controlled electric access to the practice with a ramp for wheel chair access. Home visits were available by both the GPs and a nurse practitioner for those unable to attend appointments at the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice supported patients living in two care homes. Care home staff were given a direct access number to the practice bypassing the reception for quick access.
- Patients over 75 years of age were prioritised to be seen on the day.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example eligible older people were offered flu, pneumococcal and shingles vaccinations.
- In conjunction with other local care agencies through the Pro-Active Care model which covered two per cent of adult practice patient list with more complex needs the practice provided care that was tailored to their individual needs and overseen by a named, accountable GP.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice had a process to liaise with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Longer appointments and home visits were available when needed.
- The practice provided informative literature and lifestyle advice for most long term conditions.

Families, children and young people:

- 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 A&E attendances.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice provided contraceptive advice and provided contraceptive implants and intrauterine device, or IUD.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 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.

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

- The needs of this population group 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, face to face consultations were available on the day as well as pre bookable up to three days in advance. Pre bookable appointments were also available every second Saturday morning of each month.
- Telephone consultations with a GP and the nurse practitioner were available which supported patients who were unable to attend the practice during normal working hours.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice supported vulnerable patients to access various support groups and voluntary organisations, for example, referrals were made to Age UK's personalised integrated care programme (a joint approach by Age UK with local voluntary organisations and health and care services which aimed to provide medical and non-medical personalised support for older people living with multiple long-term conditions who are at risk of unplanned hospital admissions).
- Patients newly diagnosed with cancer were given the opportunity for a face to face or telephone consultation to assess their situation and needs.
- Longer appointments were available for patients with a learning disability.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. A practice funded mental health nurse provided care and support for this population group.
- The practice offered flexible appointments during weekdays and one Saturday morning each month to ensure maximum uptake of mental health reviews. Patients who did not attend reviews were followed up with telephone calls by the practice funded mental health nurse.
- Patients newly diagnosed with depression were given the opportunity for a face to face or telephone consultation to assess their situation and needs.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

Results from the July 2017 annual national GP patient survey showed patients' satisfaction with how they could access care and treatment. There were 302 surveys sent out and 103 were returned. This represented about 1% of the practice population.

- 80% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 80%.
- 51% of patients who responded said they could get through easily to the practice by phone; CCG 67%; national average 71%.
- 71% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG 73%; national average 76%.
- 74% of patients who responded said their last appointment was convenient; CCG 81%; national average 81%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 43% of patients who responded described their experience of making an appointment as good; CCG 70%; national average 73%.
- 52% of patients who responded said they don't normally have to wait too long to be seen; CCG 59%; national average 58%.

GP patient survey results indicated patients were positive about the practice opening times, the ability to get an appointment and the ease of being seen on time. These results were supported by 16 of the 17 comment cards we received. However GP patient survey results also noted patient dissatisfaction in relation to getting through to the practice by phone and with the experience of making an appointment. One comment noted that at busy times it could take some time to get through to the practice by phone. Two of the seven patients we spoke with on the day of the inspection also told us about the difficulty of getting through at busy times.

The practice manager told us that they had implemented several initiatives to address the identified issues:

- Increased the number of telephone lines available to take incoming calls and introduced a system for automated telephone appointment booking and for online appointment booking.
- Increased the number of routine appointments available for GPs.
- Identified and rectified an issue with phone system which now informed patients how many callers are on hold before them.
- Conducted a patient survey on how patient accessed the appointment system, and had promoted the online services which were underutilised.
- Provided training for reception staff.

The practice told us that initial patient feedback through the NHS Health check survey (commenced July 2017)where 77 of the 85 respondents had answered positively to the question 'how easy was it to make the appointment' had been encouraging.

In addition the practice was currently:

- Working with four other local practices to provide a same day access hub for urgent on the day appointments. When implemented the three practices anticipate this would release more routine appointments at the practice on non-hub days.
- Progressing a patient survey of the accessibility of telephone consultations with a view to improve this service.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. There were 19 complaints recorded in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.

The practice learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. For example, following a complaint about dissatisfaction regarding a GP consultation, we saw that the practice had responded to the complainant giving an explanation of the clinical content and the circumstances of the consultation. We also saw that the practice had offered an apology.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, to deliver the practice strategy and address risks to it. For example the practice had invested in the new roles of a quality improvement manager and a mental health nurse in persuit of their intention of providing outstanding care. The practice was in the process of appointing a pharmacist to help with medicine reviews and medicine management issues.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example in relation to improving patient access to appointments.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

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

- There was a vision and set of values and supporting plans to achieve priorities.
- Staff were aware of and understood the vision, values and supporting plans and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. From the sample of 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 support, information and a verbal and written apology. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out,

Are services well-led?

Good

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- There were regular staff meetings including clinical and multidisciplinary and minutes were available to staff.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. However we found that some practices related to employment checks needed improvement.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. A business continuity plan was available for all staff and held off site by the practice manager.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Staff had received information governance training.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example the practice was currently undertaking a survey of patients asking their views on the appointment system.
- There was an active patient participation group. We spoke with the chair of the group who told us that the practice was responsive to feedback and had acted on several of their suggestions. For example with reducing the number of patients who do not attend their appointment and with the installation of automated electric doors to access the practice.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The

Are services well-led?

Good

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practice was accredited as a teaching and training practice and currently participated in the foundation programme providing rotation placement in primary care for one medical graduate. It also participated in the specialist training of GPs and currently supported two trainee GPs (called GP Registrars). The trainee GP we spoke with told us that they were well supported by the GPs other clinical staff and by the whole practice team.

- Patients' needs were assessed using clinical templates that had been formulated by the lead GP using best practice guidance such asthose provided by The National Institute for Health and Care Excellence (NICE) and locally by the CCG. For example in the management of sepsis, frailty, diabetes, mental health, asthma and chronic obstructive pulmonary disease (COPD). We found these template aided appropriate monitoring and treatment and care provision according to current best practice guidance.
- The practice used specially designed software to identify and follow the guidelines for shared care (amber) drugs. This software enabled the practice identify patients who required monitoring under the shared care arrangements in timely way.
- The practice had completed the NHS England productive general practice quick start scheme which aimed to spread awareness of innovative practice that released time for care. Through this scheme it was estimated that most practices could expect to release about ten per cent of GP time.