The Avenue Surgery

Quality Report

1 The Avenue
South Moulsecoomb
Brighton
East Sussex
BN2 4GF
Tel: 01273 604220
Website: www.theavenuesurgerybrighton.co.uk

Date of inspection visit: 23 November 2017
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. (Previous inspection April 2015 – Good)

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 The Avenue Surgery on 23 November 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The practice made improvements to the quality of care and treatment through the use of audit and were able to demonstrate action taken and measurable improvements as a result.
- Staff involved and treated patients with compassion, kindness, dignity and respect and they demonstrated a good understanding of the needs of the local patient population.
- The practice worked with other services to meet the needs of their complex and transient population groups.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- There was evidence of good working with the patient participation group in order to engage, listen and work with patients to ensure that services met patient needs.
- Clear action had been taken by the practice to improve antimicrobial prescribing.

Summary of findings

- Exception reporting was high in some areas; however the practice demonstrated a good awareness and understanding of this and took continuous action to encourage improvements.
- Patient satisfaction was high in relation to GP and nurse consultations and their involvement in planning and decision making about their care.
- The practice encouraged access to services by promoting online services, drop-in services for specific groups and extended hours appointments in the evening and at the weekend.

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

- Continue to work to improve exception reporting in relation to patient outcomes for those with long term conditions.

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

The Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser.

Background to The Avenue Surgery

The practice is situated in the Moulsecoomb area of Brighton and provides general medical services to approximately 6,815 patients. There are two GP partners and one salaried GP (male and female). The practice also employs three practice nurses. There is a practice manager and a team of ten reception and administrative staff.

Opening hours are 8.30am to 12pm and 3pm to 6.30pm Monday to Friday with extended hours in operation on Mondays and Tuesdays from 6.30pm to 7.30pm and alternate Saturdays from 8.00am until 11.00am. The practice is closed Monday to Friday between 8.00am and 8.30am and between 12.00pm and 3.00 pm. During this time the practice has a GP on duty who can be contacted via the out of hour's service which is detailed on the practice's answer phone message. In addition pre-bookable nurse appointments and GP/practice nurse diabetic clinic appointments available from 2.00pm.

The practice provides a wide range of services to patients, including minor surgery, asthma and diabetes clinics, cervical screening, contraception and sexual health clinics, childhood immunisations, minor surgery, smoking cessation and ante and post-natal care. It provides a young person's sexual health drop in clinic for patients aged under 25. Patients don't have to be registered with the practice to attend.

The practice has a higher than average percentage of its population aged between 5 and 14 years of age and under the age of 18. It also has a higher than average percentage population with income deprivation, placed in the second most deprived decile and particularly affecting children and older people. The practice has higher levels of unemployment than both the national and clinical commissioning group averages. There are a higher than average proportion of patients aged between 20 and 24, with a transient student population registered at the practice. It has less than average percentage of its population aged over 65 years.

The practice has opted out of providing Out of Hours services to their own patients. Patients are able to access Out of Hours services through NHS 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 clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite 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.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an on-going basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- 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.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis. Reception staff had received training and had an understanding of when to escalate patient concerns to clinical staff.
- 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 care records we saw 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.
- 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.
- There was evidence of actions taken to support good antimicrobial stewardship.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 and had taken action to make improvements to prescribing levels.
- 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.

Good

Are services safe?

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

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.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons identified themes and took action to improve safety in the practice. For example, we viewed records of a meeting held where a data confidentiality breach had been reviewed and discussed with relevant staff, including external professionals involved. The practice manager kept a record of which staff had received relevant information relating to lessons learned following incidents so that they could be assured that all staff had been involved and informed as necessary.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

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.
- There was negative variation in relation to the number of antibacterial prescription items prescribed, showing a higher than average level of antibiotic prescribing within the practice. GPs we spoke with told us that there had been historically higher than average antibiotic prescribing and we saw that the GPs held regular reviews and discussions and met with the clinical commissioning group (CCG) pharmacist. We saw specific action taken by the practice to reduce this which included undertaking full cycle audits of antibiotic prescribing to demonstrate improvements and raise awareness. They had also used techniques such as delayed prescribing and had produced patient information resources to raise awareness of the use of antibiotics and alternative ways of managing symptoms where appropriate.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

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 medication.
- 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. Patients were supported to access both community rapid response services and a local rapid access for older people clinic in order to work proactively to reduce the likelihood of admissions to hospital.
- 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:

- Patients with long-term conditions had a structured 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. For example, they worked with community and proactive care services to provide care for people in their own homes where they had a number of house bound patients.
- Staff who were responsible for reviews of patients with long term conditions had received specific training, including in relation to asthma, diabetes and chronic obstructive pulmonary disease.

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 in line with the target percentage of 90% or above for children aged two, however fell below the target for babies. The practice had a good level of understanding of this and worked with families to raise awareness and engage with them to improve uptake. Specific examples of action taken include practice nurses providing vaccines in the community or in patient's homes to improve uptake.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice had six weekly meetings with health visitors and school nurses to discuss children with problems.
- The practice had a dedicated midwife for pregnant teenagers.

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

- The practice's uptake for cervical screening was 89%, which was in line with the 80% coverage target for the national screening programme. Exception reporting for this area was higher than average at 19% compared with the CCG average of 9.2%, however the practice had a higher than average transient student population which impacted this.

Good

Are services effective?

(for example, treatment is effective)

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example, before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patients on the learning disability register received an annual review.
- Monthly multi-disciplinary meetings were held where patients with complex needs would be reviewed with the involvement of community nursing and social services colleagues where appropriate.

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

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was better than the national average of 86%.
- 98% 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 better than the national average of 90%.
- 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 a discussion and advice about alcohol consumption (practice 92%; CCG 80%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 88%; CCG 92%; national 95%).

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. Where appropriate, clinicians took part in local and national improvement initiatives. For example, the senior GP partner held the joint clinical lead within the locality for the proactive care service.

The most recent published Quality Outcome Framework (QOF) results were 97% of the total number of points available compared with the clinical commissioning group (CCG) average of 81.7% and national average of 96%. The overall exception reporting rate was 25% 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.)

- Exception reporting was particularly high in some areas, such as chronic obstructive pulmonary disease (COPD) where it was over 29% compared with the CCG figure of 14%. In asthma exception reporting was 52% (compared with the CCG figure of 10%). The practice was aware of the areas where exception reporting was high and understood that issues such as low socio-economic factors and a transient student population were influencing this. The practice had worked with the CCG and other services to improve patient recall, including working closely with community services and providing education and information leaflets to patients. Alerts were used on the patient record system so that reception staff could encourage patients to book in for a review when accessing the practice by phone or in person.
- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that included an assessment of asthma control was 75% compared with the CCG average of 71% and the national average of 76%.
- The percentage of patients with diabetes in whom the last blood pressure reading was 140/80 or less was 84% compared with the CCG average of 72% and the national average of 78%.
- The practice used information about care and treatment to make improvements and was actively involved in quality improvement activity. For example, an audit of two week wait cancer referrals had been carried out to determine the cancer diagnosis rate of these referrals and reasons for missed referrals.

Good

Are services effective?

(for example, treatment is effective)

Improvements to clinical practice as a result included a four week review and follow up with patients who had been given a two week wait referral. The percentage of new cancer cases using this referral route was 68% compared with the CCG average of 53% and the national average of 50%. Where appropriate, clinicians took part in local and national improvement initiatives.

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. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, one of the practice nurses was studying for their advanced nurse practitioner qualification.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, probationary reviews, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach 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. Monthly multi-disciplinary meetings were held with other professionals to review the care of patients with complex needs and those at the end of life.
- 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. One of the GPs had a special interest in end of life care and provided some out of hours support to a local hospice.

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.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. Two of the practice nurses were trained in smoking cessation techniques and provided support for patients to stop smoking.
- The practice had worked with other agencies to provide information sessions for patients on improving their health. For example, through the provision of information about cancer screening during flu vaccination clinics.

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.
- Written consent was obtained for all minor surgical procedures.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services effective?

(for example, treatment is effective)

- The practice monitored the process for seeking consent appropriately.

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 11 patient Care Quality Commission comment cards we received were positive about the service experienced. This is 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. Three hundred and forty four surveys were sent out and 107 were returned. This represented about 1% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 96% of patients who responded said the GP gave them enough time; CCG - 84%; national average - 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 93% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 84%; national average - 86%.
- 98% of patients who responded said the nurse was good at listening to them; (CCG) - 91%; national average - 91%.
- 99% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 98% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 85% of patients who responded said they found the receptionists at the practice helpful; CCG - 89%; 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.
- Staff communicated with patients in a way that they could understand.
- 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 proactively identified patients who were carers by asking about this during the registration process and when undertaking reviews. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 166 patients as carers (1.5% of the practice list).

- A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.
- Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time to meet the family's needs or by giving them advice on how to find a support service. One patient told us they were visited at home following the death of their spouse.

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 in line or above average compared with local and national averages:

Good

Are services caring?

- 94% 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%.
- 94% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 80%; national average - 82%.
- 98% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 93% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 84%; 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.

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. For example, extended opening hours, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments.
- Extended hours appointments were available on a Monday and Tuesday evening and on alternate Saturday mornings.
- The practice improved services where possible in response to unmet needs. For example, the practice sexual health clinic on a weekly basis for people under the age of 25 that was open to patients not registered at the practice. Patients were able to access the clinic on a 'drop-in' basis.
- GPs held their own patient lists and repeat prescriptions were completed by the patient's own GP which enabled continuity of care.
- The facilities and premises were appropriate for the services delivered. Consulting rooms were all on the ground floor and there was wheelchair access to patient areas within the building.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice worked closely with local proactive care services to coordinate care for their patients who were housebound. Practice nurses would visit housebound patients to administer flu vaccines at home.
- There were information boards within the practice specifically aimed at different groups within the patient population. These included young people, women and children, men, older people and carers.
- The practice worked with community organisations to provide information resources specifically targeted at the patient population. For example, one organisation attended the practice during flu vaccination clinics specifically to raise awareness about cancer screening for men.
- The practice worked with NHS Digital around the use of information and technology to promote improved access using online services. This involved patients receiving teaching sessions in the practice on how to access online services via their smart phones. The practice reported seeing a threefold increase in online access since this training took place.
- The practice took action to communicate and engage with patients outside of the usual parameters in order to improve access to services. For example, they had improved the cancer screening uptake by telephoning patients to explain the importance of screening.

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 GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.
- The practice had good relationships with a range of support groups and services for older patients.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients with diabetes were given longer appointments for their annual diabetes review with the lead GP and nurse.
- The practice had a higher than average prevalence of patients with diabetes and with respiratory conditions such as asthma and chronic obstructive pulmonary disease (COPD). The practice proactively worked with patients and with other services to improve the health of people with long-term conditions. Examples included

Good

Are services responsive to people's needs?

(for example, to feedback?)

working with patients to improve their self-management of COPD and recognise the distinction between infective and non-infective exacerbation and reduce the use of unnecessary antibiotic prescribing.
- Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Families, children and young people:

- Twenty two per cent of the practice population was aged 16 or under.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- GPs would see more than one family member where only one appointment had been made.
- The practice ran a weekly sexual health clinic for under 25s.

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

- The practice has a high proportion of students registered, with more than 14% of the adult population in full time education. The practice were aware of the challenges in providing continuity of care for this transient population. Specific services geared towards them included the ability to access appointments via drop in, including a young person's sexual health clinic.
- 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, extended opening hours and Saturday appointments.
- Telephone and consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including patients who were housebound, frail and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability where necessary.
- Translation services were available for patients who did not use English as a first language.

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. Practice nurses were trained in providing support for patients with dementia, including in relation to Deprivation of Liberty and the Mental Capacity Act.
- The practice provided annual reviews for patients with dementia or those on the serious mental illness register.
- The practice worked closely with the psychiatric liaison service at the local NHS trust and the mental health urgent response service to provide support to patients experiencing mental health emergencies.

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.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. Three hundred and forty four surveys were sent out and 107 were returned. This represented about 1% of the practice population.

- 81% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.
- 61% of patients who responded said they could get through easily to the practice by phone; CCG – 76%; national average - 71%. Members of the patient participation group (PPG) told us that recent changes had been made to the phone system to improve access in response to feedback from patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 88% 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 - 88%; national average - 84%.
- 91% of patients who responded said their last appointment was convenient; CCG - 85%; national average - 81%.
- 73% of patients who responded described their experience of making an appointment as good; CCG - 77%; national average - 73%.
- 69% of patients who responded said they don't normally have to wait too long to be seen; CCG - 59%; national average - 58%.

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. Nine complaints were received 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 and also from analysis of trends. It acted as a result to improve the quality of care. For example, a complaint from a patient about a delayed diagnosis resulted in the GP conducting a significant event review and sharing the outcome and learning points with the rest of the practice.

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, capacity and skills to deliver the practice strategy and address risks to it.
- 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, they were aware that their patient population lived in one of the most deprived areas of the city and had a significant transient population with a large student cohort. They were aware of how this impacted the practice and worked closely with the CCG and other services to ensure the continuation of high-quality services. They were actively involved in a local cluster of practices as part of a city wide structure where improvements in quality and the future of primary care services was planned.
- 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 clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy 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. Patients received an apology when things went wrong and were informed of actions to prevent the same things happening again. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. Their significant event reporting process included prompts to consider both duty of candour and any requirement to report notifiable incidents.
- 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 annual appraisals or probationary reviews as appropriate 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 had received equality and diversity training. 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 proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- 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 safety alerts, incidents, and complaints and there were clear systems in place to act on, review and learn from these.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. For example, an audit of an oral anticoagulant (a medicine that reduces the coagulation of the blood and prolongs the clotting time) showed improved monitoring of kidney function during the second cycle of the audit. Monitoring had improved from 86% to 96% during a four month period. Further audit cycles were scheduled.
- The practice had plans in place and had trained staff for major incidents.
- 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.

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.
- There was an active patient participation group (PPG). Members of the PPG told us they felt listened to and involved in the development of the practice. Specific changes they told us about as a result included improvements to the telephone system and a review of seating in the waiting area.
- 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. For example, staff were committed to improving engagement and support for patients living in disadvantaged or vulnerable circumstances. They engaged with other services to ensure that the practice services were meeting patient need and to learn collaboratively in order to make improvements.

Are services well-led?

Good

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

- Staff knew about improvement methods and had the skills to use them. Specific action taken to ensure improvements had included improving cancer screening figures, following up patients by phone who did not attend screening appointments and improving monitoring of two week wait cancer referrals.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.