Allerton Road Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on the 18 February 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The provider should:

- Continue with efforts to recruit a permanent male GP to improve outcomes for male patients.

Summary of findings

- Continue to actively liaise with commissioners and stakeholders to increase patient engagement to improve outcomes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Data showed patient outcomes were at or below average for the locality. This included the rates for cervical cancer screening and immunisations. However, the practice was working with local stakeholders to increase the rates of screening and immunisations to improve patient outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Although data from the national patient survey showed that patients rated the practice lower than others for some aspects of care, this was not borne out by patients we spoke with on the day or by comments cards patients had completed.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

All permanent clinical staff at the practice were female, which presented difficulties for male patients from the large Orthodox Jewish patient group. This was recognised by the practice, but it had been unsuccessful in attempts to recruit a permanent male GP.

Are services well-led?

Good

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients aged over 75 had a named GP.

People with long term conditions

Good

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

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

There were systems in place 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.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Rates for the standard childhood immunisations were lower than the CCG and national averages. However, this had been recognised by the practice, which was working with local stakeholders to improve immunisation uptake.

Summary of findings

Working age people (including those recently retired and students)

Good

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

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

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for most patients eligible and had plans to run dedicated clinics to review the remainder. It offered longer appointments for people with a learning disability.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 8 patients attending for appointments and a member of the Patient Participation Group (PPG) and reviewed 18 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. Patients we spoke with said they were generally happy with the service provided and they had noted improvements since the new provider had taken over the practice in 2013.

Almost all the patients' comments cards were very positive about the service. They said the practice offered an excellent service and that staff were efficient, helpful and caring. However, some concerns were mentioned, relating to the waiting time for appointments, and continuity of care due to the practice's use of locum doctors.

Areas for improvement

Action the service SHOULD take to improve

- Continue with efforts to recruit a permanent male GP to improve outcomes for male patients.
- Continue to actively liaise with commissioners and stakeholders to increase patient engagement to improve outcomes.

Allerton Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. It included a second inspector, a GP, a practice nurse, a practice manager and an expert-by-experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Experts who take part in the inspections are granted the same authority to enter registered persons' premises as the Care Quality Commission (CQC) inspectors.

Background to Allerton Road Medical Centre

Allerton Road Medical Centre operates from purpose built premises. The practice is part of the NHS City and Hackney Clinical Commissioning Group (CCG) which is made up of 43 general practices and is a member of the North East Hackney Consortium with four other practices.

The practice has been run since 2013 by the Hurley Clinic Partnership (Hurley), which operates 22 locations across London. The practice is registered with the CQC to provide the regulated activities of Diagnostic and screening procedures, Family planning, Maternity and midwifery services, and the Treatment of disease, disorder or injury.

The practice provides NHS primary medical services through an Alternative Provider Medical Services (APMS) contract to approximately 4,700 patients, 80% of whom are from the Orthodox Jewish community.

The clinical staff at the practice is made up of two GPs, a nurse practitioner and a health care assistant, all female. One of the GPs was on maternity leave, while the other worked part-time, covering four clinical sessions a week. Locum cover was being provided. There is a practice manager and an administrative team of four. There is additional management and administrative support available when needed from the Hurley corporate team.

The practice surgery hours are 7.30am to 6.30pm Monday, Tuesday and Friday, 7.30am to 7.00pm on Wednesday and 8.00am to 7.00pm on Thursday. The practice reception answered phone calls between 8.00am and 6.30pm Monday to Friday. Access for early and late appointments, when the receptionists were off duty was by buzzer. The practice has opted out of providing out-of-hours (OOH) services and has a contract in place with the local OOH provider. When the practice is closed, callers are referred to the local OOH provider. Contact details for the OOH provider is also given on the practice website, as is information on the NHS 111 service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice including information published on the NHS Choices website and the National Patient Survey and asked other organisations such as Healthwatch, NHS England and the NHS City and Hackney Clinical Commissioning Group (CCG) to share what they knew about the service. We carried out an announced visit on the 18 February 2015.

During our visit we spoke with a range of staff including GPs, the nurse and non-clinical staff. We also spoke with members of the Hurley corporate team who were providing additional management and administrative support. We spoke with 8 patients attending for appointments and a member of the Patient Participation Group (PPG) and reviewed 18 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw a record of an incident where a patient had been aggressive with reception staff. An action plan was drawn up and implemented, advising staff how to deal with similar future incidents and led to a revision of staff rotas so that at least two receptionists were on duty at one time. In addition, we saw that one of the GPs had dealt appropriately with a safeguarding concern about a child, informing the local child protection team and health visitor.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed summary records of 13 significant events that had occurred during the last twelve months and saw this system was followed appropriately. Significant events were a standing item on the monthly practice meeting agenda to review actions from past significant events and complaints. Specific meetings to discuss and review significant events were held as necessary. Data regarding significant events and complaints was also passed on to Hurley's corporate management team, as part of Hurley's standard performance monitoring process. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. Staff showed us the system used to manage and monitor incidents. We tracked a number of incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, a GPs' absence meant in one case that a patient's complaint was not suitably addressed within the timescales required by the NHS complaints policy. Learning consisted of staff being reminded that complaints should be prioritised in accordance with the deadlines set out in both the NHS policy and the practice's policy. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were received by GPs and the practice manager and disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical and staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Staff confirmed the process worked well and mentioned as an example a recent alert regarding a particular batch of Ventolin inhalers.

Reliable safety systems and processes including safeguarding

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

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

There was a system to highlight vulnerable patients on the practice's electronic records. We saw that appropriate

codes were used. These included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or risks associated with female genital mutilation. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. We saw minutes of meetings where vulnerable patients were discussed.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Staff knew of the procedure for ensuring that medicines were kept at the required temperatures, and what action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Staff told us that the practice followed Hurley corporate medicines management policy, which we saw was available on the practice computer system.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. We saw evidence that noted the actions taken in response to a review of prescribing data. For example, an audit of opiate prescribing, carried out in May 2014, highlighted that advice given to patients was sometimes poorly recorded and clinicians were reminded to fully document advice. There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked 15 patient records which confirmed that the procedure was being followed.

The practice had systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. No controlled drugs were kept at the premises.

The practice used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that the nurse and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to, either under a PGD for the nurse, or for health care assistant in accordance with a PSD from the prescriber.

The practice had established a service for patients to pick up their dispensed prescriptions at a number of local chemists and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

Cleaning was done by a contractor, in accordance with cleaning schedules and records were kept. The practice had monthly meetings with the contractor to monitor and

review performance. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We found the premises to be generally clean and tidy.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The policy had been reviewed in December 2014. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There were also policies for fluid spillages and needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last two years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Clinical waste was appropriately segregated, managed and disposed of by a licenced contractor. We saw a waste audit had been carried out in September 2014.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). A risk assessment had been carried out by an independent expert in July 2013 and was due to be repeated in July 2015. We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. We saw that equipment testing and calibration was last carried out in November 2014.

All medical instruments were single-use and appropriately disposed of after use. We found one box of syringes with a use by date of July 2014. We showed this to staff who immediately removed it for disposal.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that the practice used Hurley's central human resources management system which recorded the staff recruitment process, including evidence of pre-employment checks being carried out and on-going training. These included, for example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

Good

Are services safe?

to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw minutes which confirmed that risks were discussed at GP partners' meetings and within team meetings. There were emergency processes in place for patients with long-term conditions and for identifying acutely ill children and young people and staff showed us examples of referrals that had been made. The practice accident book contained instructions for dealing with patient emergencies.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked on a monthly basis. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We saw that staff carried out a monthly check of the emergency medicines to ensure they were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We found some dressings in the first aid kit that were out of date. Staff removed the dressings when we pointed them out and agreed to introduce a system for monitoring the kit.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. There was provision to relocate the services to a practice nearby. The document also contained relevant contact details for staff to refer to. For example, contact details were included for electricity and gas suppliers should the supplies fail. The plan was last reviewed in 2014

The practice had carried out a fire risk assessment in January 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that fire drills were carried out.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GPs and the nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff, including locums, via email. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. Information was also set out in the City and Hackney CCG and Hurley newsletters which were passed to staff by email.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. We looked at 15 patients' healthcare records, including patients with long term conditions. The records showed that regular health checks were carried out by GPs, with appropriate referral of patients to other services. Feedback from patients confirmed they were referred to other services or hospital when required.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. This was done either by phone, appointment at the surgery or a home visit.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us nine clinical audits that had been undertaken in the last 12 months. An number of these, for example relating to frequent attenders at Accident and Emergency and Warfarin prescribing, had had been completed, allowing any changes in practice approach or performance to be monitored. The audits also included a review of diagnostic requests made by the practice between April and October 2014, and referrals for dermatology and paediatric ear, nose and throat conditions. The audits brought to light a number of learning points and resulted in actions. For example, the audit of paediatric ear nose and throat referrals had highlighted the fact that children attending Orthodox Jewish schools do not have hearing tests on entry. As a result the practice was investigating the possibility of carrying out hearing tests itself.

We saw that performance monitoring was a standard agenda item for practice meetings. The practice monitored information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice achieved 96.2% of the total QOF target in 2014, which was 1.9% above the CCG average and 2.7% above the national average. Specific examples to demonstrate this included:

Good

Are services effective?

(for example, treatment is effective)

- Performance for asthma-related indicators was better than the CCG and national averages.
- Performance for cancer-related indicators was better than the CCG and national averages
- Performance for mental health-related indicators was better than the CCG and national averages

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The practice monitored this information and other data to check on performance. This included information collected by Hurley relating to all its locations for comparison. The practice monitored patients' comments left on the NHS Choices website. The practice participated in local benchmarking run by the CCG and the local consortium of practices. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. These were discussed at practice meetings and were responded to appropriately. Staff spoke positively about the culture in the practice and discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved.

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

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice worked closely with a local nursing home, where a number of its patients resided. The practice had found that due to cultural and religious issues the majority of patients and their families did not engage with it regarding palliative care.

The practice kept a register of patients identified as being at high risk of admission to hospital. All patients on the list had had their care plans reviewed. The practice also kept registers of various vulnerable groups, for example patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions, for example patients with diabetes. We were shown data that 91% of patients on the diabetes register had received an annual foot check and 67% had undergone retinal screening. The practice told us that 14% of the eligible patients had either declined the screening or had not attended appointments. The poor uptake was an issue being discussed with the CCG, the local Public Health team and NHS England.

The practice showed us data that 14 (41%) of the 34 patients on the learning disabilities register had received an annual review and had plans in place to run dedicated clinics to review the remainder of patients. The practice gave us data after the inspection to confirm that a further 12 patients (35%) had received their annual reviews at the clinics. The practice showed us data confirming that 87% of patients on the mental health register with a care plan had had an annual review.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were generally comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the doctors had received training provided by the CCG relating to mental health and the practice nurse had just completed training specific to children's health care and minor ailments. The practice

Good

Are services effective?

(for example, treatment is effective)

nurse and health care assistant had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties, for example, in administering vaccines and seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice at 12.93% were in line with the national average of 14.4%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice showed us evidence of monitoring follow-ups to ensure inappropriate follow-ups were documented and that none were missed.

The practice held multidisciplinary team meetings once a month to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, health visitors and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Fifty-two of the practice's patients were resident at a nearby nursing home. GPs did fortnightly visits to the home and had regular meetings with the home's management. Staff told us that this had led to improvements in the way repeat and acute prescriptions were processed, how samples were handled and tested and how emergencies were dealt with by the duty doctor.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and was awaiting further training for staff before this became fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw audit evidence that the practice monitored the completeness of these records and that action had been taken to address shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Good

Are services effective?

(for example, treatment is effective)

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw examples of reviewed care plans on patients' records. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area. The practice recognised that performance in some areas, such as health checks, cervical screening and immunisations, was below CCG or national averages. The practice and service commissioners had known of the issue for some time. We were told it was due to cultural and religious considerations with the patient group, which is predominantly of Orthodox Jewish background. The practice was working with the CCG, the local authority Public Health team and NHS England to engage more with the patients group and improve outcomes.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. It sent patients letters every month inviting them for the health checks and they were advertised on the practice website. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice's performance for cervical screening programme uptake was 76%, which was below the national average of 81%. The practice was working with the CCG, the local authority Public Health team and NHS England to improve this. We were informed that attendance for cervical smears had increased by 25% since Hurley took over the practice. We asked for details of this, but figures had not been provided by the time we came to draft our inspection report. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was below average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 57.66%, and at risk groups 38.54%. These were below the national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 58.9% to 64.5% and five year olds from 45.6% to 84.4%. These were below the CCG averages.

Staff told us that the low uptake rates were due to cultural issues within the major patient group. The practice was working with the CCG and NHS England to promote the benefits of immunisation and increase patient uptake.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015, completed Care Quality Commission (CQC) comments cards, comments left by patients on the NHS Choices website and comments fed back to the practice's Patient Participation Group (PPG) (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 70% of respondents describe their overall experience of the practice as good or very good. However, the practice was scored slightly below average for its satisfaction scores on consultations with doctors and nurses. For example:

- 81% said the GP was good at listening to them compared to the CCG average of 86% and national average of 89%.
- 75% said the GP gave them enough time compared to the CCG average of 83% and national average of 87%.
- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 85% said the nurse was good at listening to them compared to the CCG average of 87% and national average of 91%.
- 88% said the nurse gave them enough time compared to the CCG average of 87% and national average of 92%.
- 88% said they had confidence and trust in the last nurse they saw compared to the CCG average of 94% and national average of 97%

Patients completed CQC comment cards to tell us what they thought about the practice. Patients' comments on the day and the 18 completed cards we saw were consistently more positive than the national patient survey results about the service experienced. We noted from its annual reports that overall patient experience had not been a concern for the patient participation group. Patients said they felt the practice offered an excellent service and that staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four of the patients mentioned delays in obtaining appointments. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. A patient told us that when no appointments were available, practice staff would phone them if there had been any cancellations in the meantime, freeing up available slots. Two others mentioned problems getting appointments with their preferred GPs.

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

We saw that staff followed the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was the potential for private conversations between patients and reception staff to be overheard, but we noted that reception staff were sensitive to this and were careful to ensure that patients' privacy was respected. A private room was available should patients wish to discuss matters away from the waiting area. We saw that respondents to the patient survey were positive regarding the receptionists, with 90% saying they found the receptionists at the practice helpful compared to the CCG and national averages of 87%. Patients we spoke with and those who completed comments cards were similarly very positive about the reception staff.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

Good

Are services caring?

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded generally positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. The results were marginally lower or comparable with CCG and national averages, for example:

- 76% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 81%.
- 87% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 90%.
- 85% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 85%.

Patients we spoke with on the day of our inspection were more positive than the national patient survey results. They told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients' involvement in planning and making decisions had not been a concern for the patient participation group.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. One of the GPs was Jewish and therefore familiar with the cultural and religious practises of this large patient group. With the support of the CCG and NHS England, the practice was actively trying to engage with patients from the group to improve outcomes.

We looked at a number of patient records during the inspection. We saw that care plans were drawn up and there was evidence of patients' involvement in agreeing the plans. The practice showed us data confirming that all patients with on the end of life register had care plans in place. We saw that children were treated in an age-appropriate way, which patients confirmed in their comments to us.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were generally positive about the emotional support provided by the practice and rated it well in this area. The results were marginally lower or comparable with CCG and national averages, for example:

- 79% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 85%.
- 84% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were consistently positive. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. A patient told us that the nurse and staff had been very sensitive to their relative's needs.

Notices in the patient waiting room, informing patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Staff told us that all patients on the carers register were offered annual flu vaccinations.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. None of the patients we spoke with had had need for bereavement support.

The practice had signed up to the frail and elderly home local enhanced service, under which each patient on the

Good

Are services caring?

housebound list had an initial home visit, lasting at least one hour. Thereafter, two or three subsequent visits were made during the year. The practice told us that if a frail or elderly patient required a same day appointment the duty GP was informed and all efforts made to accommodate the request either by a telephone consultation or an emergency appointment with a GP or nurse. One of the patients we spoke with confirmed their parents were given same day appointments because of their advanced age.

The practice was also contracted to provide the severe mental health local enhanced service. This enhanced service requires all practices to have completed 10 hours of mental health training, have regular multidisciplinary team meetings with the consultant psychiatrist and primary care liaison officer and to review recovery plans for patients with mental health returning to primary care. The practice was also required to review all patients on the mental health register at least once a year. We saw that 41 of the 70 patients eligible had had reviews and we were told plans were in place to review the remainder before April 2015.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and where possible systems were in place to address identified needs in the way services were delivered. The practice was working with the City and Hackney CCG, the local authority Public Health team and NHS England to engage with the large Orthodox Jewish patient group.

We saw evidence that the practice regularly engaged with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised. The practice is part of the North East Hackney Consortium with four other practices. The practice manager was chair of the CCG practice managers' forum.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

Hurley took over the practice in 2013, when it was noted that there was a high proportion of Orthodox Jewish patients on the list. Staff told us that in during initial discussions with patient representative groups, concern had been expressed by patients at the loss of the previous GPs who had been of their faith. Both Hurley and practice staff had reassured patients that they would be respectful of their faith, and would seek to tailor the service to meet specific requirements. For example, it was recognised that there would be a high demand for appointments on Thursdays, as Fridays were reserved for Sabbath preparation, so Thursday hours were therefore extended.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG). For example, patients had expressed a wish to the PPG for reception staff to wear a uniform, to ensure that their arms were covered, meeting the cultural needs of the Orthodox Jewish patients and this had been implemented.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. New patients applying for registration were not required to provide proof of identification or address before seeing a doctor. The practice followed the corporate Hurley policy to "welcome all comers" and encouraged asylum-seekers and homeless people to register as patients. The majority of the practice population were English speaking patients, but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The premises were purpose built, with two stories. The four consultation rooms were on the ground floor, with offices upstairs. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was sufficient space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

The practice employed two permanent GPs. At the time of the inspection, one was on long term leave and the other was part time, working three clinical sessions and three administrative sessions per week. Cover was being provided by locums. Both the permanent doctors were female. The majority of patients were from the Orthodox Jewish community and cultural and religious issues meant that male patients might be particularly reluctant to see female doctors. The issue had been raised by the patient participation group and identified by the practice as having an impact on service delivery. The practice was making use

Good

Are services responsive to people's needs?

(for example, to feedback?)

of male long-term locum doctors to in an attempt to address the matter and had advertised for a permanent male GP, but had found it difficult to attract applicants. Staff told us that attempts to appoint a male GP would continue. We saw that information was provided in the reception area providing contact details for a local men's healthcare group.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice surgery hours are 7.30am to 6.30pm Monday, Tuesday and Friday, 7.30am to 7.00pm on Wednesday and 8.00am to 7.00pm on Thursday. The practice reception answered phone calls between 8.00am and 6.30pm Monday to Friday. Access for early and late appointments, when the receptionists were off duty was by buzzer. The practice has opted out of providing out-of-hours (OOH) services and has a contract in place with the local OOH provider. When the practice was closed, callers were referred to the local OOH provider. Contact details for the OOH provider were available on the practice website, as was information on the NHS 111 service.

Routine appointments could be booked up to six weeks in advance. The average wait for a routine appointment was two weeks. Emergency appointments were available throughout the day, being released at 8.00am for morning appointments and 2.00pm for those in the afternoon. Appointments were 10 minutes long, but longer double slots could be booked if needed, for example for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits and telephone consultations with GPs were also available. Patients could also consult Hurley doctors online via the practice website and would receive a response within one working day. We asked for further information regarding how many of the practice's patients were using this online facility, but it had not been received by the time we came to draft the inspection report. Home visits were made to three local care homes every fortnight and to those patients who needed one.

The patient survey information we reviewed showed patients responded generally positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 77% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.
- 69% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73%.
- 61% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.
- 80% said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 73%.

Patients we spoke with were generally satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day, if they felt their need was urgent, although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. However, some patients were not happy with the two week wait for routine appointments and some found it difficult to book appointments with their named GPs. Staff told us this was most likely because one of the permanent GPs was currently on leave and the other worked part time. Comments received from patients also showed that those in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The extended hours made appointments available outside of school hours for children and young people and were convenient for working age patients. The practice recognised that due to local cultural and religious requirements, Thursday appointments were in demand and had extended opening hours accordingly.

The practice had weekly chronic disease clinics, run by the nurse and health care assistant, carrying out asthma reviews, COPD reviews and spirometry, diabetes reviews and hypertension reviews. There was also a dedicated diabetes clinic, run by a specialist hospital nurse, for

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients having difficulties in managing their health. A baby clinic was run twice a month and one of the administrative staff telephoned new mothers to offer post-natal checks and first immunisations for their babies.

The practice worked closely with two care homes for patients experiencing poor mental health, running dedicated clinics for residents and attending the homes if needed. Staff had completed training in mental health and learning disabilities.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was provided to help patients understand the complaints system, with leaflets available in the reception area and information on the practice's website. Some of the patients we spoke with were aware of the process to follow if they wished to make a complaint, although none had had reason to do so. Nine written complaints had been received in the last 12 months, with a further 19 verbal complaints being appropriately recorded for review and action as necessary. We found they were satisfactorily handled, dealt with in a timely way, openness and transparency. None had been referred to the Ombudsman.

The practice reviewed complaints to detect themes or trends. We saw that complaints were an agenda item at practice meetings which assisted in monitoring and we saw minutes confirming all staff were able to learn and contribute to determining any improvement action that might be required. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, when a patient had complained about no emergency GP appointment being available, staff were reminded to inform patients of possible alternatives, such as an appointment with the nurse, or a telephone consultation.

The practice also routine sort general feedback from patients, with comment slips available in the reception area and via a facility on its website.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose. The practice vision and values included a commitment to providing patient centred care of high quality in a safe and comfortable environment, by working in partnership with commissioners and other stakeholders. Members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the on Hurley's internal electronic system accessible on any computer within the practice. These included policies on equal opportunities, bullying and harassment, chaperoning and whistleblowing. We saw that the policies and procedures had been reviewed annually and were up to date. An electronic record showed that most staff had accessed and read the policies. Reminders were issued to staff via the system when updates were issued.

The practice had an appropriate leadership structure with named members of staff in lead roles, such as safeguard and infection control. Staff we spoke with were clear about their own roles and responsibilities and knew who to go to in the practice with any concerns.

The lead GP and practice manager, supported by the Hurley corporate team, took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF results showed that the practice was generally performing in line with national standards. Whether results were lower than national averages, the practice was actively working on ways these could be improved, for example by engaging with the local patient group to promote immunisations and cervical screening. We saw that QOF data was regularly discussed at monthly team meetings and actions were planned to maintain or improve outcomes.

The practice showed us nine clinical audits undertaken in the past 12 months. Although only one had been repeated by the time of our inspection, they were to be used to monitor quality and systems to identify where action should be taken. For example, an audit of dermatology referrals had shown that one out of the 15 referrals was inappropriate and seven of the 15 could have used an alternative pathway. The high number of referrals for benign moles led to the practice arranging a teaching session about referral criteria for moles. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes of these meetings and found that performance, quality and risks had been discussed.

The practice used the Hurley human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

GPs and managers were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. Administrative staff had transferred from the previous service provider. The practice told us that there had been problems with staff relations following the transfer and that a lot of work had been done to improve matters. This included a team building and development, which staff told us had been productive and successful.

Are services well-led?

Good

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

There were regular staff meetings and staff were given the opportunity to be involved in discussions about how to run the practice and how to develop the practice. We saw from minutes that team meetings were held regularly and staff told us they had the opportunity to raise any issues of concern. Staff told us that regular away days were being planned.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the Patient Participation Group (PPG), surveys and complaints received. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice PPG had 18 members, of whom 15 were female and three male. The ethnic make up was 12 Orthodox Jewish, five British and one of mixed background, with an age range from 35 to 85+. The PPG and the practice were keen to recruit more young people and male patients. Patients registering with the practice were encouraged to join the PPG and it was advertised by various means within the practice, on the website and at local chemists. We saw the results of the last patient survey had been considered in conjunction with the PPG. The results and actions agreed from the surveys were available on the practice website. We spoke with a member of the PPG and they were positive about the role they played and told us they felt engaged with the practice.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice. The practice monitored comments left by patients on the NHS Choices website and responded to them. Comments were discussed at team meetings.

The practice had also gathered feedback by an annual staff survey and generally through staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that the practice had an up to date policy covering clinical supervision of GPs and nurses and supervision of non-clinical staff. We looked at a number of staff records and saw that regular appraisals took place, which included a personal development plan.

The practice had completed reviews of significant events and other incidents and we saw these were discussed at staff meetings to ensure the practice improved outcomes for patients.