Greenford Avenue Family Health Practice

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 8 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive services and for being well-led. We found the practice to be good for providing services for the population groups of 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 and people experiencing poor mental health (including people with dementia).

Our key findings 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.
- Patients' needs were assessed and care was delivered following best practice guidance. Staff had received training appropriate to their roles.
- Patients said they were treated with kindness, compassion, and respect and that they were involved in decisions about their care and treatment.
- Most patients said they found it easy to make an appointment and that appointments were convenient. However, some patients mentioned it was difficult to get through on the phone and available appointments were not always suitable for those who worked.
- 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.
- Information about services and how to complain was available and easy to understand.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Display the chaperone policy in all clinical and treatment rooms.

Summary of findings

- Ensure that all staff who may be required to perform chaperone duties have received appropriate training.
- Ensure all staff have received basic life support training.
- Maintain a formal risk log that records how any identified risks have been assessed and managed.
- Ensure that the second stage of first cycle clinical audits commenced are completed.
- Ensure that patients are provided with information about the out of hour's service provider.

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. Significant events were discussed as a standing agenda item at the monthly practice meeting to share learning and action plans. There was a clinical lead for safeguarding and all staff were up to date with role appropriate child protection training. The practice undertook regular infection control audits and there was evidence of improvement to infection control procedures as a result of the action plans identified. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had a recruitment policy for new staff, however staff records were not maintained consistently to reflect this.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes, for example cervical screening rates and immunisation uptake, were at or above average for the Clinical Commissioning Group (CCG) area. Staff referred to guidance from 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. Staff we spoke with were aware of guidance to assess capacity and gain consent and could demonstrate examples where they had used this guidance in practice. There was evidence of annual appraisals and personal development plans for all staff that included identifying and meeting training needs. Staff worked regularly with multi-disciplinary teams. The practice undertook clinical audits but had yet to complete second audit cycles to demonstrate that improvements had been made and reviewed.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with kindness, dignity and respect, and they were involved in decisions about their care and treatment. Data from the National GP Survey was in line with patient feedback received. The practice was above average in the Clinical Commissioning Group (CCG) area for its satisfaction scores on consultations with nurses. Information to help patients understand the services available was easy to understand. We also observed staff to be kind, polite, and helpful towards patients attending the practice and when speaking to them on the telephone.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with NHS England and the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Most patients said they found it easy to make an appointment and that appointments were convenient. However, some patients mentioned it was difficult to get through on the phone and available appointments were not always suitable for those who worked. The practice had good facilities and was accessible to patients with physical disabilities. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Complaints were a standing agenda item at the practice meeting to share learning and improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision to put patients' care first. 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 to discuss performance monitoring, significant events and training. The practice proactively sought feedback from patients through the Friends and Family Test, National GP patient survey and Patient Participation Group (PPG) led surveys. We saw evidence that the practice had made changes to service as a result of feedback from patients. The practice had a PPG, though it was noted attendance at recent meetings had diminished. Feedback was gained from staff through regular team meetings and staff we spoke with felt supported to raise comments or concerns. 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. All patients over the age of 75 years had a named GP to co-ordinate their care. The practice was using risk stratification tools to identify patients at high risk of hospital admission and were developing integrated care plans with these patients to reduce the risk. There were regular multi-disciplinary team meetings with district nurses, community matrons and palliative care teams to discuss and meet the needs of frail elderly patients. The practice offered GP and nurse domiciliary review of housebound patients. Memory assessments were offered proactively with appropriate referral to secondary services if required. The practice offered seasonal flu vaccinations to patients over 65 years of age in line with national guidance.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients were offered nurse-led annual review with any concerns identified discussed with the relevant GP. The practice held regular multi-disciplinary team meetings with district nurse, community matron and the palliative care team to discuss and manage the needs of patients with long term conditions. Integrated care plans were being developed for patients at high risk of hospital admission. Seasonal flu vaccinations were offered to patients aged over six months and less than 65 years of age in defined clinical risk groups.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice uptake rates for childhood immunisations and cervical smears were at or above the Clinical Commissioning Group (CCG) area average. Child protection cases were discussed as a standing agenda item at the practice team meeting. Health visitors attended the multi-disciplinary team meeting to discuss any complex cases. The practice offered routine maternity clinics and well women services.

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). Urgent appointments were available the same day with the duty doctor and telephone consultations could be booked for discussing issues that did not require a face-to-face appointment. The practice had

Summary of findings

extended opening hours on a Saturday from 09.00 am to 11.00 am for pre-bookable appointments. There was the facility to book appointments or request repeat prescriptions online for patients who were unable to attend or call the surgery during working hours. The practice offered NHS Health Checks for patients 40 to 75 years of age and any issues identified would be promptly reviewed by a GP.

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 maintained a register of patients with learning difficulties and they were offered annual medical review. Patients with memory problems were offered screening and referral to secondary services if appropriate. Vulnerable patients were discussed as a standing agenda item at the monthly practice meeting. The practice provided medical services to a nearby hostel for patients who were homeless.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care provided to people experiencing poor mental health (including people with dementia). The practice kept a register of patients experiencing problems with mental health. Patients with schizophrenia and bipolar disorder had comprehensive care plans agreed with the patient documented in the medical notes. These patients were discussed at quarterly Integrated Care Management (ICM) meetings.

Summary of findings

What people who use the service say

During our inspection we received 21 Care Quality Commission (CQC) comment cards that patients had completed and spoke with 12 patients including one member of the Patient Participation Group (PPG). Overall the feedback given was positive. The majority of patients were satisfied and commented on the high quality of care delivered and felt the staff were good at listening. Results from the National GP patient survey published in January 2015 showed 63% of respondents described their overall experience of the surgery as good.

Two of the 21 CQC comment cards described frustration with the telephone system when booking appointments. This was reflected in results from the National GP Patient survey with only 44% of respondents reporting it was easy to get through to the surgery on the phone and 47% described the overall experience of making an appointment as good. Patients we spoke with also described difficulty getting through to the surgery on the phone. We were told that the practice had plans to replace the current telephone system but this was still in progress.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Display the chaperone policy in all clinical and treatment rooms.
- Ensure that all staff who may be required to perform chaperone duties have received appropriate training.
- Ensure all staff have received basic life support training.
- Maintain a formal risk log that records how any identified risks have been assessed and managed.
- Ensure that the second stage of first cycle clinical audits commenced are completed.
- Ensure that patients are provided with information about the out of hour's service provider.

Greenford Avenue Family Health Practice

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, practice manager and expert by experience who were granted the same authority to enter the practice premises as the CQC inspector.

Background to Greenford Avenue Family Health Practice

Greenford Avenue Family Health Practice is a well-established GP practice located within the London Borough of Ealing and is part of NHS Ealing Clinical Commissioning Group (CCG) which is made up of 79 GP practices. The practice provides primary medical services to approximately 5000 patients. The practice is part of the Family Health Practice Group which also provides GP services at two other practices in the area.

The practice holds a core General Medical Services (GMS) contract and is commissioned for the provision of local enhanced services which include extended hours, minor surgery and International Normalised Ratio (INR) monitoring used to monitor the effectiveness of the anticoagulant warfarin.

The practice team comprises one male GP partner, one male and one female salaried GP, one female nurse practitioner/clinical governance manager, one female practice nurse and one female medical assistant who undertook health care assistant duties but had trained as a doctor in their native homeland. The practice is supported by an administration team led by a practice administrative lead, four reception staff and one secretary.

The practice opening hours are 8.00 am to 6.30 pm Monday, Tuesday, Wednesday and Friday and 8.30 am to 1.30 pm on Thursday. Appointments are available in the mornings from 8.30 am to 11.30 am Monday to Friday and in the afternoon from 3.00 pm to 6.00 pm Monday, Tuesday, Wednesday and Friday. Pre-bookable appointments are available on a Saturday from 09.00 am to 11.00 am which can also be booked by patients registered at the two other GP practices in the Family Health Practice Group. The practice has opted out of providing out of hours services and have arranged with an alternative provider to provide cover when the practice is closed. Patients are directed via the practice website and recorded telephone message to contact 111 NHS advice line when the practice is closed. The practice provides a wide range of services including child health and development, minor surgery, travel immunisation, well woman clinics, family planning, maternity care and diabetes and asthma management.

The age range of patients is predominately 15-54 years old and the number of 0-19 year olds and 25–44 year olds is greater than the England average. The practice population deprivation score is higher compared to the England average. The practice patient population has a mixed ethnic profile.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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.

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

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 and asked other organisations to share what they knew. We met with NHS England, NHS Ealing Clinical Commissioning Group (CCG) and Healthwatch Ealing and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 8th January 2015.

During our visit we spoke with a range of staff including GPs, the practice administrative lead, practice nurses and administration staff. We also spoke with 12 patients including one member of the Patient Participation Group (PPG). We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed patient records, policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints. We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before our visit.

Good

Are services safe?

Our findings

Safe track record

The practice 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, a recent incident was reported when some blood tests received electronically had not been reviewed for two days. The practice reviewed the process for handling test results and found these results had not been matched to a GP due to a recent change in the way that the pathology services addressed test results. The practice alerted the administration staff to the problem and provided training on how to manage results that are not addressed to a recipient. The incident was discussed and reflected on at the practice meeting.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of four significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and all reported events were reviewed annually. 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 said they were encouraged to do so.

The practice had an adverse and significant event reporting and auditing procedure that detailed the process to follow when reviewing significant events. Staff used significant event forms to record information on the details of the event, what went well, what could have been done better and what learning points were identified. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example staff education on managing aggressive patients following an incident in the waiting room.

National patient safety alerts were disseminated by email and in the monthly clinical team meeting to practice staff. We saw for example, that safety information about the management of patients with suspected Ebola virus had been discussed at a recent practice team meeting.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had child protection and adult safeguarding policies available on the shared drive for all staff to access. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. For example GPs had all received safeguarding vulnerable adults training and child protection training to level three, practices nurses to level two and administration staff at level one. This training was updated by clinical staff at 18 month intervals and three yearly by administration staff. 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 on the practice shared drive and in a folder in the reception area.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. 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. Due to clinical duties we were told the safeguarding lead could not routinely attend local safeguarding conferences but that appropriate child protection reports were made available for these meetings in a timely manner. We saw safeguarding vulnerable patients was a standing agenda item at the monthly practice meeting.

There was a system to highlight vulnerable patients on the practice's electronic records, for example if a child was subject to a child protection plan this would be flagged on

their medical records. The practice maintained a child protection register of patients subject to child protection plans. The practice nurse had a procedure for following up on children who had not attended appointments for childhood immunisations that involved sending regular letter invitations every eight weeks.

There was a chaperone policy and this included documentation in the patient notes when a chaperone had been offered or present. (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). A chaperone poster was displayed in the waiting room but there was no information in the clinical rooms about the chaperone policy. Reception staff would act as a chaperone if nursing staff were not available and a Disclosure and Barring Service (DBS) check had been undertaken for these staff members. We were told that administration staff had not undertaken recent chaperone training but that this would be sourced.

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. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy and records of daily fridge temperature recordings maintained confirmed this.

Processes were in place to check medicines and vaccines 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.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The medical assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescribing GP. We saw signed sets of up to date PGDs. We saw evidence that nurses and the medical assistant had received appropriate training to administer the medicines referred to in both the PGDs and PSDs.

There was a system in place for the management of high-risk medicines such as warfarin, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The nurse practitioner was the lead for the anticoagulation service and used an international normalized ratio (INR) software programme to measure and manage INR levels for patients taking warfarin.

The practice had a repeat prescribing policy document. All prescriptions were reviewed and signed by a GP before they were given to the patient, with the exception of those prescribed by the nurse practitioner who was trained as an independent prescriber. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place that included daily, weekly and monthly cleaning tasks and cleaning records were kept.

The nurse practitioner was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received training about infection control specific to their role. Infection control updates were discussed at the practice team meetings. We saw for example that an update about the use of spill packs for the cleaning of body spillage had been presented at a recent practice meeting. We saw evidence that the practice completed infection control audits. The last audit had been completed in November 2014 and we saw action plans from the audit had been completed in the required time frame. For example, the audit found that curtains had not been cleaned every six months in line with national guidelines. As a result the curtains were cleaned within two weeks of the audit and the practice had arranged to have disposable curtains fitted within the next six months. Minutes of practice meetings showed that the findings of the audits were discussed.

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. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Good

Are services safe?

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.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). However, this had been noted in the last infection control audit and as a result the practice had arranged for a Legionella risk assessment to be completed during the week commencing 12th January 2015.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment; for example weighing scales and blood pressure measuring devices were tested and maintained annually. All portable electrical equipment was routinely tested and stickers displayed on equipment indicated the last test date as December 2014.

Staffing and recruitment

The practice had a recruitment policy that included a pre-employment checklist. However, staff records we reviewed did not consistently contain the required pre-employment documents according to the policy. For example, some records did not contain any pre-employment references, qualifications or proof of identity. We were told that this was because some administration staff had been at the practice for many years and that this information may not have been collected when they commenced employment at the practice. The policy was followed for the recruitment of new members of staff. Criminal record checks through the Disclosure and Barring Service (DBS) had been undertaken for all staff.

Staff told us the arrangements for planning and monitoring the number and mix of staff were currently under review. 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 had a locum handbook for any locum doctors required to work at the practice that included information on the staffing structure at the practice and Ealing Clinical Commissioning Guidance (CCG) for sessional GPs.

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 to the practice. The practice also had a health and safety policy that included fire safety, hazardous waste disposal, premises maintenance, equipment maintenance, medicine storage and personal safety and dealing with aggression. Health and safety information was displayed for staff to see and the administrative lead was the practice health and safety representative.

The practice did not maintain a formal risk log that recorded how any identified risks had been assessed and rated and mitigating actions put in place to reduce and manage the risk. However, we were told that any risks were discussed at the monthly practice team meeting and were shown an example where the practice administrative lead had shared the recent findings from an infection control audit with the practice team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There was an emergency incident procedure that advised staff on how to respond to use of the emergency alarm. Records showed that clinical staff had received training in basic life support in the last 12 months, however not all non-clinical had completed recent training which we were told would be addressed. Emergency equipment was available including access to medical oxygen, a nebuliser and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis, breathing difficulties, infection and chest pain. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. A protocol was in place for the re-ordering of emergency medicines when the expiry date approached.

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

Good

Are services safe?

included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to for example, contact details of utility services and account details.

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

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 minutes of practice meetings where new guidelines and medical updates were disseminated, for example information about the Ebola virus had recently been discussed at the practice team meeting. We found from our discussions with the GPs and nurses and clinical records reviewed that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were revisited when appropriate.

The GPs told us there were leads in some clinical areas, for example a lead in safeguarding and one of the GPs had a specialist interest in women's health. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

National data showed the practice's antibiotic prescribing was similar to the national average. The practice used computerised tools to identify patients with complex needs who had multi-disciplinary care plans documented in their case notes. The practice had a system in place to review patients recently discharged from hospital. All discharge summaries were passed to the duty doctor who responded to any urgent issues and non-urgent issues were referred to the patient's GP. The practice aimed to review patients who had unplanned admissions within three days of discharge.

All the GPs we spoke with used national standards for referrals, for example they used urgent two week referrals for cases of suspected cancer. The administrator followed up referrals to ensure they had been received and the practice maintained an audit trail to monitor the process. We were told there was a process to discuss rejected referrals from secondary care to review the process and identify alternative management options. We were advised the GPs were proactive in reviewing their own referral process, for example through audit and submitting evidence at annual appraisal to identify any learning needs.

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

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us five clinical audits that had been undertaken in the last year. For example, one of the GPs had conducted an audit of their referrals to secondary care gastroenterology services to assess their appropriateness and identify areas for improvement. Through this audit they found some referrals could be prevented through the use of direct access to outpatient gastroscopy in clinically appropriate cases. The GP had made an action plan to implement this into their practice. Other examples included a retrospective audit to confirm that the GP who undertook minor surgical procedures was doing so in line with their registration and National Institute for Health and Care Excellence guidance. We were shown several examples of clinical audit in first cycle stage that were due to be reviewed and completed in the next four months. These included monitoring vitamin B12 levels for patients taking a type of oral anti-diabetic medicine and a review of medicines in patients with chronic kidney disease.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of 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). For example, we saw audits were in progress on anti-coagulation prescriptions in patients at high risk of stroke and prescribing in patients at risk of osteoporosis as part of the medicine management incentive scheme.

The practice also used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. The practice had met all the minimum standards for QOF 2013/2014 in asthma, chronic kidney disease, chronic obstructive pulmonary

Good

Are services effective?

(for example, treatment is effective)

disease (COPD), dementia, depression, heart failure, learning disabilities, palliative care and stroke and had met the majority of the standards in high blood pressure and diabetes. This practice was not an outlier for any QOF (or other national) clinical targets.

Staff we spoke with told us clinical audit was mostly GP led. The GPs were aware of their responsibilities in performing clinical audit to drive improvements to practice and professional development. We saw audit results were discussed at the practice clinical team meeting.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that 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. We saw an example to confirm that after receiving an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) about an anti-sickness medicine the GPs had reviewed the use of the medicine in their patient population.

The practice had a palliative care register and had regular multi-disciplinary meetings to discuss the care and support needs of these patients and their families.

The practice also 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 comparable to other services in the area. For example, the number of unplanned emergency admissions, antibiotic prescribing and prescriptions of Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) were similar to other local practices 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 safeguarding vulnerable adults and child protection training. We noted a good skill mix among the doctors with one GP having an additional diploma in obstetrics and gynaecology and other GPs having training certificates for family planning and minor surgery. All GPs were up to date with their yearly continuing professional development requirements and all either had 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. The practice had a clinical appraisal document available on the shared drive to help staff prepare for their annual appraisal. Our interviews with staff confirmed that the practice was proactive in providing training and we saw training courses attended by staff were regularly discussed at the clinical team meetings to share learning with the team.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and management of chronic conditions such as asthma, COPD and diabetes. The nurse practitioner was the Caldicott Guardian (senior person responsible for protecting confidentiality of patients) for the practice and also the lead for the anticoagulation service and we saw training records to confirm they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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 services both electronically and by post or fax. The practice had a communications policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day that they were received. The duty GP was responsible for responding to all urgent results received on the same day There was one instance in the last year when blood results received had not been reviewed for two days as they had not been addressed to a named recipient. This incident was logged as a significant event and discussed at the practice meeting to educate the

Good

Are services effective?

(for example, treatment is effective)

administration staff on the procedure to follow if results arrive without a recipient name. There had been no further incidents of results not being reviewed appropriately since this had been discussed.

The practice held quarterly multi-disciplinary team meetings (MDT) to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, the palliative care team and community matron and decisions about care planning were documented in a shared care record. The practice nurse also attended a twice monthly network MDT with other local practices and GPs to discuss complex cases and case reviews with an education component so that clinicians could learn from each other's experiences.

Information sharing

Information was shared between the practice and the local GP out-of-hours provider via fax. Electronic systems were also in place for making referrals, and the practice made 92% of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record. (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 system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 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 in their practice. The practice had a Mental Capacity Act policy to assist staff required to make decisions on a patient's capacity and how to support them to make their own decisions.

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 and updated annually. 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 Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was documented using a consent form with a record of the relevant risks, benefits and complications of the procedure and this was scanned into the electronic patient notes. The same consent form was used for joint injections performed at the practice.

Health promotion and prevention

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 local area. This information was used to help focus health promotion activity such as healthy lifestyle choices information, exercise referral, smoking cessation and referral to alcohol and drug abuse support.

It was practice policy to offer a health check with the practice nurse 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 were told by GPs that they opportunistically offered advice to patients to help maintain or improve mental, physical health and wellbeing during consultations. For example, offering smoking cessation advice to smokers or referral to drug and alcohol services if required. The practice also offered NHS Health Checks to all patients aged 40 to 75 years and GPs would follow up on patients if they had risk factors for disease identified at these health checks.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were all offered an annual physical health check. Ninety-four per cent of patients on the learning disability register had received a check up in the last 12 months. The practice had also identified the smoking status of 81% of patients over the age of 16 and actively offered in-house smoking cessation support to these patients.

The practice's performance for cervical smear uptake was 82%, which was average for the CCG area. The practice had a cytology screening programme policy that included the procedure to follow for patients who did not attend for appointments. The practice nurse co-ordinated follow up of patients who did not respond to invites for smears and childhood immunisations and letter reminders were sent or phone calls made every eight weeks for those due invitations. One of the administration team also maintained a list of patient's overdue smears as a failsafe and would update the practice nurse with any changes.

The practice offered a full range of immunisations for children, travel vaccines including yellow fever and flu vaccinations in line with current national guidance. Childhood immunisation uptake rates for 2013/2014 were above or at average for the CCG depending on the age and vaccine The uptake rates were between 82% - 94% at 12 months, 87% - 99% at 24 months and 74% – 84% at five years. There was a clear policy for following up non-attenders by the practice nurse. Fifty-nine per cent of patients aged over 65 years of age and 33% of patients aged over six months and less than 65 years of age at clinical risk had received a seasonal flu vaccination in 2013/14, which was slightly below the CCG average.

The practice was pro-active in contacting patients who did not respond to national bowel and breast screening programmes to encourage them to participate.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, polite, and helpful towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with told us that they were treated well by the practice staff and that they were treated with kindness, dignity and respect. Many of the completed Care Quality Commission (CQC) comment cards we received referred to staff as helpful, caring, good at listening, respectful, professional and kind.

Evidence from the latest GP national patient survey published by NHS England January 2015 showed that patients were satisfied with how they were treated. Seventy-five per cent said that the last GP they saw or spoke to was good at listening to them and 80% found the receptionists at the surgery helpful. The practice was above average in the Clinical Commissioning Group (CCG) area for its satisfaction scores on consultations with nurses. Ninety-five per cent of respondents said they had trust and confidence in the last nurse they saw and 82% said the last nurse they saw or spoke to was good at giving them enough time.

All consulting rooms were sound secure with consultations remaining private. It was noted that conversations at the reception desk or over the phone could be overheard by patients in the waiting room. A room was available if patients wanted to discuss something away from the reception area. We were told that this room was also made available for breast feeding mothers or as an isolation waiting area. We observed that the positioning of the computer screens in the rear part of the reception area could potentially be viewed from the patient waiting area. This was brought to the attention of the practice manager who confirmed that this would be addressed.

The practice had a chaperone policy displayed in the waiting area, however this information was not displayed in consulting rooms. Patients had the option to see a male or female GP when booking an appointment. The practice had a communication standards policy that set out the standards to follow when communicating with patients both in person and in writing. There was also a confidentiality policy to protect the right of patient's confidentiality. These policies were available on the intranet for all staff to access.

Care planning and involvement in decisions about care and treatment

The results of the GP national patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 73% of respondents felt the GP was good at explaining treatment and results and 71% said the last practice nurse they saw or spoke to were good at involving them in decisions about their care.

Patients we spoke with during our inspection told us they felt involved in decision making about the care and treatment they received. They also told us the GPs were good at listening to them and explained results and treatment options well. Patient feedback on CQC comment cards we received reflected this feedback.

An on-line translation service was available for patients who did not speak English as their first language and was used to involve patients in decisions about their health care and to obtain informed consent.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. CQC comment cards we received reflected this feedback. Information on the waiting room noticeboards was provided on symptom detection, condition management, support organisations, alternative care providers and local community information.

The practice kept a register of patients who were carers, including those under the age of 18 years. The practice computer system alerted GPs if a patient was a carer. Written information was available in the waiting room for carers to raise awareness of support available to them for example, Carers UK Support Network.

Procedures were in place for staff to follow in the event of the death of one of their patients. This included informing other agencies and professionals who had been involved in the patient's care, so that any planned appointments, home visits or communication could be terminated in order to prevent any additional distress. Any patient deaths were discussed in the practice weekly team meeting so that staff were all aware when a patient had died.

The practice maintained a list of patients receiving palliative care and this was available to the out of hour's provider. The practice had close links with the palliative care nursing team and held quarterly meetings with them.

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 systems were in place to address identified needs in the way services were delivered.

NHS England and the local Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

There was a named GP for all patients over 75 years of age. Memory assessments were offered where there were concerns regarding memory and patients were referred onwards to memory services if required. The practice used a risk assessment tool to identify patients at high risk of hospital admission and they were developing integrated care plans with these patients to reduce this risk. We saw evidence that care plans had been completed for elderly patients with complex needs. We were told the GPs were performing regular medicine reviews for patients with polypharmacy (prescribed multiple medicines). Home visits were available for patients unable to attend the practice due to illness or immobility. The practice also offered nurse led domiciliary assessments that included taking blood for warfarin monitoring for housebound patients.

The practice offered nurse led annual review of patients with long-term conditions. Integrated care plans were also being developed with patients who had long term conditions and were at high risk of admission. We saw evidence that these care plans were being completed. The practice held regular multi-disciplinary team meetings attended by district nurses, the community matron and palliative care team to discuss and manage the care plans of patients with complex needs.

The practice offered a full childhood immunisation programme in line with national guidance and the uptake rates were above the CCG area average. The practice nurse had a procedure to follow up on patients who had not attended their immunisation appointments. We saw child protection cases were a standing item agenda at the monthly practice meeting to update all staff on any change. Complex cases were discussed at regular multi-disciplinary team meetings attended by health visitors. The practice offered routine maternity clinics and well women services. Post-natal six week mother and baby check appointments were given extended time slots.

The practice had extended opening hours on a Saturday between 9.00 am and 11.00 am for pre-booked appointments. The practice had facilities to book or cancel appointments and request repeat prescriptions online for patients who were unable to attend or call the surgery during working hours. These services were promoted on the homepage of the practice website.

The practice maintained a register of patients with learning difficulties and they were offered annual medical review. Patients with memory problems were offered screening and referral to secondary services if appropriate. We saw that vulnerable patients were discussed as a standing agenda item at the monthly practice meeting to update staff on any changes to plans or circumstances. The practice provided medical services to a nearby hostel for patients who were homeless.

The practice kept a register of patients experiencing problems with mental health. Patients with schizophrenia and bipolar disorder had comprehensive care plans agreed with the patient documented in the medical notes.

The practice had also 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, feedback from the patient survey carried out by the PPG showed patients were having difficulty making appointments and as a result the practice made more pre-bookable appointments available and provided the option for telephone consultations.

Tackling inequity and promoting equality

The practice had access to online translation services for patients who did not have English as their first language. Translators when required provided face-to-face and telephone translation services.

There was wheelchair access to the practice site via a rear door as the main entrance was not wheelchair accessible. We noted the doorbell for this rear door was not an appropriate height for wheelchair users. We observed staff answering the doorbell promptly to assist patients into the building. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and

Good

Are services responsive to people's needs?

(for example, to feedback?)

allowed for easy access to the treatment and consultation rooms. The premises were spread over two floors, there was no lift access to the upstairs rooms but we were told that staff would move to one of the rooms downstairs if they were seeing a patient who could not manage the stairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8.30 am to 6.00 pm Monday to Wednesday and Friday and from 8.30 am to 1.30 pm on Thursday. Pre-bookable appointments were offered on Saturday mornings from 09.00 am to 11.00 am which can also be booked by patients registered at the two other GP practices in the Family Health Practice Group. Urgent appointments were available same day with the duty doctor. Routine appointments could be made within 48 hours and pre-bookable appointments were available up to four weeks in advance. Home visits were offered to patients who could not attend the practice due to illness or immobility. Telephone consultations could also be booked for discussing issues that did not require face-to-face appointment, for example discussing test results. The practice sent text message reminders to patients before appointments. There was the facility for patients to book or cancel appointments online for patients who had registered for this service.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, they were directed to 111 NHS advice line and the same information was provided on the practice website. However information about the out-of-hours service provider was not supplied in the recorded telephone message or on the practice website.

Some of the patients we spoke were satisfied with the appointment system and felt it was easy to get an appointment at the practice. This was reflected in the National GP patient survey with 83% of respondents reporting that the last appointment they got was convenient and 74% saying they were able to get an appointment or speak to someone on the last time they tried. However, others commented that it was hard to get through on the phone to book an appointment and available appointments were not convenient for those who worked and waiting lengths from appointment time were long. This was also supported by the National GP patient survey as only 44% of respondents found it easy to get through on the telephone and 37% felt they did not have to wait too long to be seen. We were told that the practice had plans to replace the current telephone system but this was still in progress.

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. Patients were asked to make formal complaints in writing or by completing a complaints form available at reception and addressing them to the practice administrative lead. The complaint would be acknowledged within three working days and once investigated a written response to the complaint would be provided.

We saw that information was available to help patients understand the complaints system in the practice complaints leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the four complaints received in the last 12 months and found they had been managed in a timely manner according to the complaints procedure. There was evidence that learning from complaints were explored and considered as part of the complaints procedure. We saw complaints were discussed as a standing agenda item at the monthly practice meeting to share learning outcomes and improve service. We were told complaints were reviewed annually to detect themes or trends.

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 put patients' care first. We found that details of the practice vision were displayed on the practice website. The practice's strategy was centred on practical development of the service, for example on opening hours, staffing and premises. We were told there was no public display of the practices values as they were still draft subject to NHS approval. Staff we spoke with knew and understood the practice vision and their responsibilities in relation to this.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. This included a clinical governance policy that included guidance on patient involvement, clinical audit, evidence based management, staff feedback, risk control and continuing professional development. This policy had been reviewed annually and was up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. Staff we spoke with were all clear about their own roles and responsibilities and told us they felt well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The practice undertook regular clinical audits to monitor quality and systems to identify where action should be taken. We were shown examples of first stage audit cycles that were due to be re-audited in the next four months.

The practice had arrangements for identifying, recording and managing risks. Significant events were recorded and discussed as a standing agenda item in the practice meeting to share learning and drive improvements. The practice held monthly clinical team meetings that included discussion of governance arrangements. We looked at minutes of the meetings from the last year and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted administration team meetings were held regularly to discuss issues relating to information governance, risk assessment and team social activities.

The practice administrative lead was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment procedure, bullying and harassment policy and equal opportunities policy. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. However, some staff we spoke were unsure where to find the staff handbook if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through the Friends and Family Test, National GP patient survey and Patient Participation Group (PPG) led patient survey. We looked at the results of the annual PPG led survey and saw that difficulty getting through on the telephone had been raised as an issue by patients. As a result, the practice had aimed to increase awareness of the facility to book appointments online by displaying the information clearly on the homepage of the practice website. They also planned to replace the current telephone system but this was still in progress.

The practice had a patient participation group (PPG) which was formed in March 2014. The initial meeting was well attended and had representatives from various population groups, however we were told attendance had dropped at subsequent meetings. The PPG met quarterly with representatives from the practice and we saw minutes to confirm that patient surveys and feedback were discussed along with planned changes and updates to the service at each practice site. The practice was recruiting patients for a virtual PPG for feedback via email for those patients who were unable to attend the PPG meetings. This was advertised on the practice website.

Are services well-led?

Good

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

The practice had gathered feedback from staff through regular team meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

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 reviewed staff records and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and we saw that training courses attended by staff were discussed at the monthly clinical team meeting to share learning with the wider team.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings, for example a recent event involving an abusive patient was discussed and learning outcomes identified including how to support staff members when managing challenging patients.