Kings Cross Road Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Kings Cross Road Surgery on 3 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, safe and responsive services. It was also good for providing services for the care provided to 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 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 that they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. For example same day urgent appointments were available.
- 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.

There were areas of practice where the provider needs to make improvements.

Importantly the provider should:

Summary of findings

- Implement a central risk register to capture all risk to patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were discussed by the management team and communicated to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. There was enough staff to keep patients safe. The practice had systems in place to ensure patients were safe including safeguarding and chaperone procedures, and processes to ensure medicines were correctly handled. Patients were treated in a clean environment and processes were in place to monitor infection control. Equipment was fit for purpose and maintained regularly.

Are services effective?

Good

The practice is rated as good for providing an effective service. Data showed patient outcomes for the current year were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was routinely referenced and used. People's needs were assessed and care was planned and delivered in line with current legislation. Staff received appropriate training for their roles and further training needs have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced. The practice was able to demonstrate completed audit cycles where changes had been implemented and improvements made.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others in the locality for several aspects of care. For example 91% of patients found the last GP they spoke with good at listening to them, which was above the Clinical Commissioning Group (CCG) average of 87%. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. The practice had a Patient Participation Group (PPG) which had recently started to meet to discuss practice concerns and to develop the annual patient survey.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and 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. There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver a high level of service to patients. 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, including infection prevention and control and medicines management, to govern activity and regular meetings to discuss governance had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active Patient Participation Group (PPG). Staff had received inductions, performance reviews and attended staff meetings. Although risks to patients who used the service were assessed and monitored, the practice did not have a risk log to ensure all risks were monitored.

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. All patients had a named GP and this was recorded within their notes 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.

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 example, the practice had undertaken annual reviews for 31 of the 37 patients on the chronic obstructive pulmonary disease (COPD) register and 27 patients had an agreed care plan. 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. Immunisation rates were relatively high for all standard childhood immunisations. For example the practice vaccinated 89.5% of children with the MMR vaccination which was higher than the clinical commissioning group (CCG) average of 87.5%. 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, this included baby changing facilities.

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 including online booking. The practice provided a full range of health promotion and screening that reflected 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 and those with a learning disability. It offered longer appointments for people with a learning disability and those who needed the support of the in house or telephone interpreting services.

The practice regularly 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. The GP also provided a report for the transition of young people in social services care to adult services.

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). Ninety five percent of people experiencing poor mental health had received an annual physical health check and 95% had an agreed care plan. 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 the services of a psychiatrist mental health worker who met with patients on a regular basis and was involved in the management of care with the GP.

The practice advised patients experiencing poor mental health how to access support groups and voluntary organisations. It had a

Summary of findings

system in place to follow up patients who had attended accident and emergency (A&E) who may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs including dementia.

Summary of findings

What people who use the service say

During our inspection we spoke with four patients at the surgery and collected 32 comment cards that had been completed by patients.

Patients were happy with the service provided and said that they were treated with respect and well cared for. Patients told us that they were involved in the decision making process regarding their treatment, and were given information about all the treatment options available to help them make their choices. They were happy that they were always able to get a same day appointment if required.

Patients we spoke with who were receiving on-going treatment were happy with the way their care was being managed and they were kept informed at all times.

We viewed the national GP patient survey for 2014 and found that 91% of patients that completed the survey said that the GP was good at listening to them. The practice scored particularly well in patients having confidence and trust in the GP (98%), which was higher than the Clinical Commissioning Group (CCG) average of 95%, and the GP giving them enough time (85%) which was also higher than the CCG average of 82%. Areas which the practice had poorer scores included finding the receptionists helpful (63%) compared to the CCG average of 85%. However in the latest patient survey carried out by the practice, 83% of patients who completed the survey were satisfied with the way they were treated by the receptionists at the practice.

Areas for improvement

Action the service SHOULD take to improve

- Implement a central risk register to capture all risk to patients.

Kings Cross Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. It included a GP advisor and a practice nurse who were granted the same authority to enter the Kings Cross Road Surgery as the Care Quality Commission (CQC) inspector.

Background to Kings Cross Road Surgery

The Kings Cross Road Surgery is a surgery located in the London Borough of Camden. The practice is part of the NHS Camden Clinical Commissioning Group (CCG) which is made up of 40 practices. It currently holds an APMS contract and provides NHS services to 2650 patients.

The practice is provided by AT Medics which is an organisation run by six GPs. AT Medics includes 19 GP practices (including Kings Cross Road Surgery), two minor injuries centres and a walk in centre. AT Medics took over the management of the practice twelve months prior to inspection and in that time have brought in standard procedures and there has been improvements shown in the care provided. Kings Cross Road Surgery serves a diverse population with many patients attending where English is not their first language. The practice serves the general population but also a large student population and large Bengali community. The practice is situated on one level and has good access to consulting rooms for those with impaired mobility. There are currently two GPs (one male and one female), a practice nurse, healthcare assistant, six administrative staff and a practice manager.

The practice is open between 8am to 6:30pm on a Monday and Wednesday, 8am and 8pm on a Tuesday, 8am and 1pm on a Thursday and 8am and 7pm on a Friday. Appointments are available from 8:30am to 6:30pm each week day except Thursday where appointments are available to 12:30pm. Extended hours appointments are available between 6:30pm and 8pm on a Tuesday and 6:30pm to 7pm on a Friday. Telephone consultations, email enquiries and home visits are also offered. The practice opted out of providing an out of hours service and refers patients to the local out of hours provider or the '111' service.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services procedures and the treatment of disease, disorder or injury.

The practice provides a range of services including child health and immunisation, minor illness clinic, smoking cessation clinics and clinics for patients with long term conditions. The practice also provides health advice, blood pressure monitoring and a specialist diabetic clinic.

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 on 3 February 2015, as part of our regulatory functions. This inspection was planned to check whether the provider is

Detailed findings

meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of 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 references 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 that we hold about the practice and asked other organisations including Camden Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 3 February 2015. During our visit we spoke with a range of staff including GPs, practice nurse, practice manager and administration staff. We spoke with patients who used the service. We reviewed 32 completed Care Quality Commission (CQC) comments cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice used reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example an incident occurred where it was not clear as to whether patient letters received from accident and emergency were being actioned appropriately. The practice put in place a system of date stamping letters as soon as they were received before scanning on to the system to ensure an accurate system of audit.

We reviewed the four safety records and incident reports recorded in 2014 and found these were discussed in management meetings and then disseminated to all practice staff via email. Events relevant to a particular staff group were discussed in the appropriate staff meeting. This showed that the practice had managed these consistently over time and could evidence a safe track record.

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 significant events that had occurred during the last two years and we were able to review these. We found no evidence that significant events were a standing item on the practice meeting agenda, however events were discussed by senior management and a dedicated meeting was held six monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Staff reported significant events to the practice manager who would log them on the computer system. We were shown the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. For example, we saw evidence of action taken as a result of patients having a delay in being referred by the GP. The practice assigned a member of staff to check that patients were seen within the appropriate time and if not they would contact the hospital. All referrals were logged on the computer and late referrals were easily identified. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to all staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example an alert was issued regarding the risk of Ebola. They also told us alerts were discussed in practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to review risks to vulnerable children, young people and adults. All staff had received both safeguarding and child protection training. Safeguarding training had been undertaken by eight members of staff; the remaining five members of staff were due to complete the training in March 2015. Child protection training had been completed by all members of staff. Clinical staff had received Level three child protection training and reception staff had received Level two child protection training. We asked members of both the clinical and non-clinical team about the training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibility to report any concerns and how to contact the relevant agencies. Contact details were easily accessible within the practice office. The practice had a dedicated GP lead for safeguarding and staff were aware of this and that they could speak to the GP if they had a concern.

A chaperone policy was in place and visible in the waiting area and in consulting rooms. Chaperone training had been undertaken by nursing staff and reception staff who were on the practice chaperone list. All staff understood their responsibilities when acting as chaperones including where to sit during the consultation. All chaperones had received a Disclosure and Barring Service (DBS) check.

The practice used the required codes on their electronic case management system to ensure that children and young people who were identified as at risk, including those who were looked after or on child protection plans, were easily identifiable. The practice used a risk stratification tool to highlight vulnerable children and

adults that were frequent hospital emergency department attenders. Those patients that were flagged were placed on the practice vulnerable patients list which was reviewed in clinical meetings. The safeguarding lead was aware of vulnerable children and adults and demonstrated good liaison with local social services which included a weekly meeting where health visitors and social workers who attended the practice, attending child protection hearings in person or providing a report if unable to attend.

Medicines management

We checked medicines stored within the 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. This also described the action to take in the event of a potential failure.

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.

Vaccines were administered by the practice nurse in line with legal requirements and national guidance. We saw evidence that the practice nurse had received the appropriate training to administer vaccines. The practice nurse was also qualified as a prescriber (a nurse qualified to issue prescriptions to patients).

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescription pad numbers were recorded before placing in printers 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 and that cleaning records were kept. Patients told us they always found the practice clean and had no concerns about cleanliness. The practice employed an external cleaning company and we viewed the cleaning log held by the practice. Any concerns regarding cleaning were raised directly with the company by the practice manager who undertook a quarterly cleaning audit.

The practice had a nurse lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and also received annual updates. We saw evidence that an infection control audit had been carried out by AT Medics (the provider of the practice) and that improvements identified for action had been completed on time. 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. The policy included spillage management, specimen handling and routine equipment decontamination. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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 had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed that legionella risk was assessed 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 (January 2015). A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example baby scales, diagnostic set, digital blood pressure monitors, spirometers, thermometers, ultrasound and vaccine fridges. Calibration last took place in January 2015.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification,

references, qualifications and registration with the appropriate professional body. Criminal records checks through the Disclosure and Barring Service (DBS) had been carried out for nine members of staff with the remaining three members of staff awaiting the completion of the check. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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 was 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 in their contracts. The practice manager maintained a staffing matrix to ensure enough staff was present to cover the practice and to plan for any shortage of staff through sickness, external training or annual leave.

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.

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. These included annual and monthly checks of the building, the environment, medicines management, staffing procedures, procedures for 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.

Risks that occurred within the practice were discussed within management meetings where an action plan would be established. The plan would then be disseminated to the remainder of the staff team through the practice meeting.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. For example staff gave examples of where acutely ill children had been brought to the practice by their parents and had been seen as an emergency by the GP. Staff spoke about ensuring that patients with a long term condition were referred to secondary care if it was noticed through their health review that their condition was deteriorating. This was also mentioned positively on patient record cards. We viewed minutes of meetings between the practice and the district nurse team that discussed the ongoing care of patients with a long term condition and those on the practice vulnerable patients register.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that nine members of staff had received training in basic life support and the remaining four were booked on the course in March 2015. Emergency equipment was available including access to oxygen 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 and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a life threatening allergic reaction that can develop rapidly) and hypoglycaemia (low blood sugar level). Processes were in place to ensure that emergency medicines were within their expiry date and suitable for use including an electronic recording system used to monitor expiry dates. All the medicines we checked were in date and fit for use. The practice had a contract with an oxygen supply company who automatically came to replace oxygen prior to expiry.

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. The document also contained relevant contact details for staff to refer to (for example, contact details of the computer maintenance company to contact if the computer system failed).

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. The practice had a fire safety log book and tested the fire alarms on a weekly basis.

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 both clinical and practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The practice ran a 'buddy' system where each member of the clinical staff was paired with a member of the administrative staff who supported them which allowed them to focus on specific conditions, and ensured that referrals were promptly made. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers and mental health conditions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

To ensure that patients who may be at a higher risk and in need of a more detailed needs assessment, a risk stratification tool was used. The tool identified the top two percent of a particular group, for example patients with a high attendance at accident and emergency (including older patients), patients with long term conditions and patients with mental health concerns. Best practice guidance was then used to discuss the issues surrounding the attendance at accident and emergency with patients and provide the most up to date care. All unplanned admissions to hospital were reviewed in clinical meetings and we were shown copies of the minutes of the meetings where individual patients were discussed. We viewed two care plans for those patients identified and saw how a plan was put in place with the practice to effectively manage their health concerns which included health checks and regular reviews. Patients were referred to local services including the community mental health team for further testing and diagnosis. A structured annual medication review was in place for all patients that received more than four medicines and were over the age of 75.

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 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 had a system in place for completing clinical audit cycles. The practice showed us four clinical audits that had been carried out within the last 12 months. Following three of these clinical audits, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, a stroke monitoring audit was carried out to assess whether the practice was achieving its targets for optimising the modifying risk factors such as blood pressure and cholesterol. The audit was carried out in June 2014 and repeated in September 2014 with a plan to carry out a further audit in June 2015. The audit showed that through the giving of lifestyle advice, the level of both blood pressure and cholesterol tests had reduced. The results of the audits were emailed to all staff and discussed within practice meetings. The remainder of the audits had yet to complete their first audit cycle.

Good

Are services effective?

(for example, treatment is effective)

The GPs told us clinical audits were often linked to medicines management information and the provider's own internal monitoring system. For example, we saw an audit regarding the prescribing of Warfarin (used to stop the blood from clotting). Following the audit, the GPs carried out medication reviews for patients who were prescribed this medicine and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average. The latest available QOF data showed that overall the practice was performing below the CCG average (96.8%) and the national average (97.1%) achieving 41.5%. This was a general figure which included all areas that QOF covered (clinical care, how well the practice was organised, patient viewed, amount of extra services offered by the practice). The practice used this information to ensure that they were on target to deliver a good service and to discuss, in both clinical and practice meetings, how service could be improved. The practice was aware of this low figure which was through the previous management of the practice not undertaking the full amount of QOF. AT Medics worked at improving the QOF in the current year (2014/2015) and have calculated that they are on target to achieve a total of 98.3%.

The clinical team was making use of Clinical Commissioning Group (CCG) benchmarking against other practices which included reviewing patient attendance at accident and emergency (A&E). Patients were contacted by the practice if they attended A&E unnecessarily and reminded them of the services provided at the practice. Clinical meetings were used to discuss and reflect on how the systems at the practice could be improved to achieve improved outcomes for patients.

Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that patients had received appointments for all routine health checks for long term conditions such as diabetes and the latest prescribing guidance was being used.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses. Three staff were due to undertake annual basic life support training in March 2015. We noted a good skill mix among the doctors with one having special interest in palliative care and another in mental health. All GPs were up to date with their yearly continuing professional development requirements and all were due to be revalidated by the end of 2015. (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 that are identified within the appraisal, for example one administrative member of staff undertook training to be a healthcare assistant to assist with this area of work.

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 and cervical cytology). Those with extended roles for example undertaking asthma reviews and the monitoring of diabetes and chronic obstructive pulmonary disease (COPD) were also able to demonstrate that they had appropriate training to fulfil these roles.

Healthcare assistants received training through the company's competency framework which included practical and written training and a scenario examination. All areas had to be signed off by one of the partners before they were able to see patients. Each healthcare assistant received a mentor to work alongside throughout their employment to offer support.

Staff files we reviewed showed that where poor performance had been identified, appropriate action had been taken to manage this.

Working with colleagues and other services

The practice engaged with other health services to ensure a multi-disciplinary approach to the care and treatment of those with complex care issues.

Good

Are services effective?

(for example, treatment is effective)

We were informed that the practice had good working relationships with the health visitor team for young mothers who are responsible for children under the age of two, the palliative care team and local mental health teams.

Blood tests, X ray results, hospital letters, information from out of hour's providers and the 111 service were received by the practice electronically, reviewed by the administration staff and passed to the GP or nurse to take the appropriate action within 48 hours. All staff understood their role and felt that the system in place worked well.

The practice held monthly multidisciplinary meetings to discuss the needs of complex patients, for example those with long term conditions and children on the at risk register. The meetings were attended by the community matrons, district nurses and social workers as necessary. Decisions about care were documented in a record card accessible to all members of staff at the surgery to enable continuity of care. The practice also held a quarterly palliative care meeting attended by the local multidisciplinary care team including, practice GPs, nurses and the palliative care nurse. We reviewed the minutes for the last two meetings which provided a patient update and the action that was to be taken. We were told that further meetings would be called in the interim period if the need arose.

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. Electronic systems were also in place for making referrals, and the practice made 80% 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. One GP showed us this task using the electronic patient record system, and highlighted the importance of this communication with A&E.

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, 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. However we did not find evidence that the system had been audited to assess the completeness of the records and to address any potential shortcomings.

Consent to care and treatment

Nine members of the clinical and non-clinical staff at the practice had received training in the Mental Capacity Act 2005 and the Children's and Families Act 2014. Four members of the non-clinical staff were due the training at a date to be set by the practice. The clinical staff that we spoke with were aware of the key parts of the legislation and were able to demonstrate how it was implemented in practice. For example, staff spoke of the need to ensure appropriate consent for treatment was obtained from a patient with dementia. We were shown evidence of care plans which required consent and found that appropriate consent had been received.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have legal capacity to consent to medical examination and treatment). We were provided with the practice policy for determining the capacity of patients under 16 to give consent and the procedure for the practice to follow.

Health promotion and prevention

All new patients were offered a consultation with the practice nurse to discuss the patient's lifestyle and to provide information to help improve their lifestyle. This included healthy eating and exercise leaflets and smoking cessation advice. Chlamydia testing and advice was also offered as part of the initial patient consultation for those patients within the age range for this testing. Sexual health advice was offered to young people and those that may be vulnerable. Patients were signposted to other health organisations that could be of service if an issue was identified. The practice also offered a full children's immunisation programme. Immunisation rates were above the Clinical Commissioning Group (CCG) rate. For example,

Good

Are services effective?

(for example, treatment is effective)

in 2013, the practice vaccinated 97.5% for the MMR and the CCG average was 89.7%. The practice telephoned patients who did not attend for vaccinations as a reminder and to encourage attendance.

The practice shared the care of mothers and children with the community midwives team and the practice nurse to provide antenatal care and support to new parents which included baby monitoring and post natal checks. Support for the families of premature babies was also given. The practice also operated a register of children at risk or in social services care and GPs attended joint meetings to discuss care. The GP also provided a report for the transition of young people in social services care to adult services. Appointments were available outside school times.

The practice offered annual health checks and advice to all patients with specific checks for those placed on the long term conditions register which included structured annual reviews, diabetes checks and blood pressure monitoring. Chronic obstructive pulmonary disease (COPD) checks were also carried out and included spirometry checks (measuring lung function). The practice had 37 patients on the COPD register and had undertaken annual reviews for 31 of those patients. The reviews included a medicines check to ensure medicines were still relevant to the condition.

Smoking status was added to patient records and patients were referred to smoking cessation classes which were run on an ad hoc basis by a local community team. The practice was unable to provide data regarding smoking cessation quit rates. The practice proactively monitored patients who may be at risk of developing a long term illness through the practice computer system. These patients were called in on an annual basis for a health check to monitor any developments.

Patients over the age of 75 had a named GP which was recorded within the notes. Weekly multidisciplinary team meetings were held with the community matrons to discuss the ongoing needs of older patients.

The practice held a register of patients with poor mental health of which currently 95% had an agreed care plan. The practice was in the process of ensuring those remaining received a care plan. The practice provided annual physical health checks to patients on the register along with regular mental health reviews. Ninety five percent had received a review. The practice worked with a mental health worker who visited the practice on a weekly basis. The mental health worker assisted the GPs in the advanced care planning for patients with dementia and attended multidisciplinary care reviews to discuss these cases. Each patient on the older persons register received a named GP contact. The practice also attended meetings with the local mental health teams to discuss the case management of patients on the mental health register where the GPs provided regular health reports for the meetings. The practice referred patients to the local memory service for assessment, the locally run chronic fatigue service, first steps child psychology service and the in house alcohol counsellor. A community counselling service was also available which the GPs referred patients to.

Flu vaccinations were offered to all patients with 67% of over 65's and 53% of patients on the at risk registers receiving the vaccination. The practice was aware of the low figures and were carrying out work to promote this with patients.

The practice had a 72% uptake for cervical screening which was in line with the latest CCG average. The practice was aware that this figure was in need of improvement and was promoting this service within the practice and sending reminders to those patients that were due for the screen.

The practice provided an in house translation service which allowed consultations and annual reviews to be undertaken in a way that enabled patients to make informed decision about their care and treatment.

Support was given to working people who became ill through medical certificates and the fit note. However the practice did not audit these certificates.

The practice had a system set up where patients could email non urgent enquiries to the practice which would be answered by the duty GP the same day.

Health advice leaflets were available within the reception area or direct from the nurse. However leaflets were only available in English. Patients were signposted to other voluntary organisations for further assistance.

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 and annual patient survey undertaken by the practice's Patient Participation Group (PPG). The evidence from these sources showed patients were positive about the service they received, that they were listened to by staff and treated with respect. Data from the national GP patient survey (431 surveys were sent out and 51 surveys were returned) showed that 91% of patients found the last GP they saw or spoke to good at listening to them, which was above the Clinical Commissioning Group (CCG) average of 87%. The survey also showed that 98% said that they had confidence and trust in the last GP that they spoke with, which was above the CCG average of 95%. In the latest PPG survey, 83% said that respect was shown by clinical staff and 88% said that clinical staff showed concern.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 32 completed cards and the majority were positive about the service experience. Patients commented staff were very friendly and efficient and felt they involved them in the planning of their treatment. They also told us that the environment was clean and safe.

We also spoke with four patients on the day of inspection, who were happy with the overall service provided.

Staff told us that all consultations were carried out in the privacy of the consulting room. Disposable curtains were provided in consulting rooms so that patient dignity was maintained during examinations. We noted that the doors to the consulting rooms were closed during a consultation to increase confidentiality. The practice provided a chaperone for any patient that made a request for one. Information on the chaperone service was on display in the reception area.

We noted that there was a small distance between the waiting area and the reception desk to ensure patients were not overheard at the desk by those waiting for an appointment. A consultation room would be made available for any patient that wished to talk to a member of staff in private before their consultation.

Staff told us that the practice had a culture of ensuring that patients were treated equally. For example, patients experiencing poor mental health or in vulnerable circumstances were able to access the service without fear of prejudice, and staff treated them equally.

Care planning and involvement in decisions about care and treatment

Patient survey information that we viewed showed patients responded positively to questions about their involvement in the planning of their care. For example, the national GP patient survey showed that 78% of patients said that the GP was good at involving them in their care, and 86% said that the GP was good at explaining test results and treatments, which were both in line with the Clinical Commissioning Group (CCG) average. The results from the practice's own satisfaction survey showed that 88% of patients said they were given appropriate explanations which helped to make their decisions about care.

Patients we spoke with on the day had no concerns over involvement in their treatment. All patients said that they were fully involved in the decision making process and that all the options for treatment were explained to them. They also told us they felt treated with respect, listened to and supported by staff to make an informed decision about the choice of treatment they wished to receive without being rushed.

Staff told us that translation services were available for patients who did not have English as their first language. Patients were asked by the receptionist if they required a translator and the service was also publicised in reception.

Patient/carer support to cope emotionally with care and treatment

The survey information we viewed showed that people were positive about the emotional support that was provided by the practice. People told us that when they needed emotional support the GP would offer support through providing an appropriate referral to another service or by providing information about how they could access relevant support groups and counselling services. Patients were contacted by the GP following discharge from hospital. Local voluntary and patient support groups were publicised in reception.

The practice had a carer's policy and the practice computer system alerted GPs if a patient was also a carer. We were

Good

Are services caring?

shown written information signposting carers to support groups. Patients who suffered bereavement were telephoned by the GP and invited to the practice to discuss how staff could be of any help.

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 a patient's 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.

The practice engaged regularly with the clinical commissioning group (CCG) to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery. For example it was identified that there was a high percentage of patients with diabetes and the practice worked with a specialist diabetic nurse to provide dedicated clinics for the management of the condition.

The practice had recently re-formed the patient participation group (PPG) and were discussing suggestions for improvement with the group which included how to improve the appointments booking system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example the provision of signage within the reception area in languages other than English advising of the provision for booking appointments and presenting samples at the reception desk.

The practice had access to face to face, online and telephone interpreting services (including British Sign Language) that could be pre booked for appointments if patients requested to use the service.

The premises and services had been designed to meet the needs of patient with disabilities. Wider doorways were in place to accommodate wheelchairs. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice actively supported patients who have been on long-term sick leave to return to work by the promotion of the 'fit note' scheme and ongoing counselling and support.

Access to the service

The practice was open between 8am to 6:30pm on a Monday and Wednesday, 8am and 8pm on a Tuesday, 8am and 1pm on a Thursday and 8am and 7pm on a Friday. Appointments were available from 8:30am to 6:30pm each week day except Thursday where appointments were available to 12:30pm. Extended hours appointments were available between 6:30pm and 8pm on a Tuesday and 6:30pm to 7pm on a Friday.

Comprehensive information was available to patients about appointments within the practice leaflet. 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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice website was being developed and contained basic contact details and information on how to book an appointment online and how to order repeat prescriptions.

Longer appointments were available for patients who needed them and those with long-term conditions or where an interpreter or advocate may be required. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one. Telephone appointments were available each day for patients unable to attend the practice or in need of health advice from a GP.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. The practice survey showed that 83% of patients were satisfied with the waiting times for appointments.

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. The practice manager was the designated responsible person who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system including posters within the waiting room and information in the practice leaflet. 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. However we were informed that verbal complaints were not noted down but handled by the practice manager at the time. The only records kept were of written complaints.

We looked at two complaints received in the last 12 months and found that these were handled appropriately in line with the practice complaints policy.

The practice reviewed complaints annually to detect themes or trends. 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. The outcome of complaints was shared in practice meetings. We reviewed the minutes and found that no policies had been changed as a result of the outcome of complaints.

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 provide quality world class and accessible health care in response to patient's needs. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included developing the practices reputation for being a caring and innovative practice, and committing themselves to providing the highest standard of care and treatment.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of practice meetings and saw that staff had discussed and agreed that the vision and values were still current.

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. We looked at six of these policies and procedures including medicines management, repeat prescribing, infection control and referral policy. All the policies and procedures we looked at had been reviewed annually and were 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 a GP lead for safeguarding. There was a named GP governance lead who took responsibility to ensure all aspects of governance was working appropriately. Governance was discussed within the weekly clinical meeting and we saw evidence of these discussions. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had set up a buddying system between clinical and administrative staff to maintain the efficiency of the practice. This included ensuring administrative and clinical staff worked together to ensure that services were maintained and that records were updated.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for the previous year (2013/2014) showed it was not performing in line with national standards. The practice was working hard to ensure that QOF was in line with the national standards for the current year (2014/2015) We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. This included prescribing audits, stroke monitoring audit and an audit into the care received by those patients with diabetes.

The practice had arrangements for identifying, recording and managing risks. The practice did not have a risk log which meant that risks to patients were not coordinated and may have been missed. However risks were discussed within clinical meetings when they arose. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, a plan had been put in place to replace the seating in the waiting area following a recent health and safety risk assessment.

Leadership, openness and transparency

We saw that full team meetings and administration specific meetings were held every two months. 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, sickness policy, induction policy, whistleblowing policy and disciplinary procedures 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.

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

The practice had gathered feedback from patients through the annual patient survey, NHS Choices website and through the practice complaints procedure. We looked at the results of the annual patient survey and 1 in 5 patients stated that they would like greater access to a GP. In response to this, the practice implemented an action plan to introduce a daily GP telephone triage clinic, healthcare

Are services well-led?

Good

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

assistant clinics and increased nurse availability to support GPs, and the promotion of online services such as booking appointments and ordering prescriptions. We reviewed comments from patients which had a common theme of the waiting room not being very comfortable. The practice manager showed us plans for improvements to the waiting area which included replacing the seating. This was dependent on funding being made available.

The practice had recently started a patient participation group (PPG). The first meeting of the PPG was attended by eight patients. The practice was working with the provider's director of patient experience, engagement and patient participation in order to develop this further. The PPG were currently looking at ways to involve the wider patient population such as the student population and the large Bengali community so that their views were heard. The meetings are held at different times of the day and publicised on the notice board in order to attract different members of the patient population.

The practice had gathered feedback from staff through staff meetings and annual appraisals. Staff told us they felt comfortable giving feedback and discussing any concerns or issues with management. They 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. However some members of staff we spoke with were unaware of the policy and where it was located.

Management lead through learning and improvement

Staff told us that the practice supported continued learning and development through training and mentoring. We looked at staff files and found that regular appraisals took place which included a personal development plan. Staff were openly encouraged to advance themselves through training for internal promotions. We were shown the competency framework that was developed for the training of healthcare assistants and were advised that a similar training programme was being developed and was to be rolled out to administrative roles.

The practice had completed reviews significant events and other incidents and shared the information and outcomes with staff to ensure the practice improved outcomes for patients. For example, following an incident where emergency equipment was required and the equipment was difficult to locate within the practice, staff were informed where the equipment was located and signage put in place to ensure it was easily identifiable.