Wentworth Medical Practice

Quality Report

38 Wentworth Avenue
Finchley
London
N1 1YL
Tel: 020 8346 1242
Website: www.wentworthmedical.co.uk

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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?	Requires improvement
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 a comprehensive inspection of the Wentworth Medical Practice on 15 and 16 October 2014. We rated the practice as 'good' for the service being safe, caring, responsive and well led. We rated the practice as 'required improvement' for the service being effective. We rated the practice as 'good' for 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 those people experiencing poor mental health (including people with dementia).

We gave the practice an overall rating of 'Good'.

Our key findings were as follows:

- Patients said that they were happy with the service provided, that they were treated with respect and were fully involved in the treatment decision process.
- Systems were in place to keep patients safe including incident reporting, safeguarding and infection control procedures.
- Staff were appropriately qualified to deliver effective care and treatment in line with National Institute for Health care and Excellence (NICE) guidance.
- The practice had an active Patient Participation Group (PPG) and proactively sought feedback from patients and used it to make improvements to services provided.
- The practice was working towards its clear vision to provide more services and to become integrated with local networks while working closely with other local practices.

However there were areas where the provider needs to make improvements.

The provider should:

- Ensure that clinical audits are completed and the practice is able to demonstrate changes implemented and the impact on patients reviewed.
- Ensure that all patients on the practice mental health register have an agreed care plan and annual health check and review.
- Ensure there is a written document of employment references on each employee file.

Summary of findings

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 learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. There were 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. Although risks to patients who used the service were assessed, the system and processes to address these risks to patients were not always implemented well enough to keep patients safe. For example not all significant event forms had been fully completed. Patients were treated in a clean environment and processes were in place to monitor infection control.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. Data showed patient outcomes 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. This included assessment of capacity and the promotion of good health. 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. However the practice were unable to demonstrate any completed audit cycles where changes had been implemented and improvements made.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. For example 69% of patients said that the nursing staff were good at involving them in their care, which was above the Clinical Commissioning Group (CCG) average of 58%. 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

Summary of findings

them. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. The practice had an active Patient Participation Group (PPG) which met regularly to discuss practice concerns and to develop the annual patient survey.

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 demonstrating 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. 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 regular governance meetings 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.

Summary of findings

What people who use the service say

During our inspection we spoke with eight patients at the surgery and collected 26 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.

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 70% of patients that completed the survey found the overall experience good. The practice scored particularly well in staff treating them with care and respect (79%), which was higher than the Clinical Commissioning Group (CCG) average of 71%, and being involved in decisions about their care (71%) which was also higher than the CCG average of 60%. Areas which the practice had poorer scores included getting through to the practice by telephone (50%) compared to the CCG average of 63%. In the latest patient survey carried out by the practice's Patient Participation Group (PPG), 72% of patients who completed the survey rated the overall service provided by the practice as either excellent or very good.

The main concern that was raised by patients was the telephone appointment system, which did not work efficiently. This was an issue the practice was aware of and was attempting to resolve through the installation of a new telephone system.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that clinical audits are completed and the practice is able to demonstrate changes implemented and the impact on patients reviewed.
- Ensure that all patients on the practice mental health register have an agreed care plan and annual health check and review.
- Ensure there is a written document of employment references on each employee file.

Wentworth Medical Practice

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 who was granted the same authority to enter the Wentworth Medical Practice as the Care Quality Commission (CQC) inspector.

Background to Wentworth Medical Practice

Wentworth Medical Practice is a surgery located in the London Borough of Barnet. The practice is part of the NHS Barnet Clinical Commissioning Group (CCG) which is made up of 69 practices. It currently holds a PMS contract and provides NHS services to 9000 patients. The practice serves a diverse population with many patients attending where English is not their first language. The practice does not have a large older population (7%) with 20% of the population under the age of 14. The practice is situated in its own premises and is arranged over two floors. Consulting rooms are available on the ground floor for those with a physical disability. There are currently seven GP's (4 male and 3 Female) who share their time between Wentworth Medical Practice and a second site in Hendon (which has not currently been inspected), two nurses, a healthcare assistant, 10 administrative staff and a practice manager. The practice opening hours are 8am to 8pm on a Monday, 8am to 6.30pm on Tuesday and Thursday, 8am to 1pm on Wednesday and 7am to 6.30pm on Friday. The practice opted out of providing an out of hours service and refers patients to the '111' service.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning 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 service to 3 local care homes.

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 15 and 16 October 2014, 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 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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including Barnet Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 15 and 16 October 2014. 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 including representatives of the Patient Participation Group (PPG). We reviewed 26 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 a delivery of vaccines was not kept appropriately in the cold chain and required disposal. The incident was reported and investigated through the significant events process. The event was discussed in a practice meeting to share learning from the incident.

We reviewed the safety records and incident reports throughout 2013 and found these were discussed in practice meetings. 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 incidents and significant events. Completed significant event recording forms were available on the computer system which identified the event, how the event would impact staff and patients and a record of the discussion within the significant event meeting. The form also included an action plan with completion dates. We looked at six events contained in the practice significant events folder for the past twelve months. We found two of the six reports had no record of the action the practice had taken. We viewed minutes of practice meetings which showed that a slot was placed to discuss significant events as they occurred, to allow discussion and learning for the staff team. Staff including receptionists and secretaries were aware of the system for raising issues to be considered at practice meetings and felt encouraged to do so. We were shown the system to manage and monitor incidents and saw records were completed in a timely manner however improvements to the overall reporting system could be made to ensure consistency in reporting.

National patient safety alerts were received directly by the clinical staff and practice manager. The practice manager was responsible for ensuring non-clinical staff were aware of the alerts. Staff told us that alerts were discussed at practice meetings to ensure that all were aware of any relevant to the practice and where any actions were needed to be taken. For example a recent alert was discussed regarding the guidance for handling any potential cases of Ebola.

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 and child protection training had recently been completed by the staff team in September 2014. Clinical staff had received Level three child protection training and reception staff had received Level one 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. If a nurse was not available to undertake chaperoning duties, a trained member of the reception staff would carry out the duty. All staff understood their responsibilities when acting as chaperones including where to sit during the consultation. The practice had a detailed chaperone policy with strict guidance to follow. 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 attending child protection hearings in person or providing a report if unable to attend.

Medicines management

The medicines management lead was a consultant pharmacist who attended the practice on a monthly basis. The practice nurse had day to day responsibilities for medicines management.

We checked medicines stored in the designated medicines store room and medicines refrigerators and found they were stored securely and were only accessible to authorised staff. A daily log of fridge temperatures was held and medicines were kept at the required temperatures. The practice provided a medicines management routine for the practice nurse and health care assistants to follow which was in line with national guidelines. A notice describing the process to follow if the refrigerator power failed was on display.

The medicines management routine stated that medicines expiry dates were to be checked on a monthly basis, and we found records confirmed these checks were being completed. All the medicines we checked were within their expiry dates. Any out of date medicines were returned to the pharmacy for disposal and recorded on the medicines stock list.

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.

There was a protocol for repeat prescribing which was in line with national guidance. The receptionist would print the prescription from the system and send for the GP to sign. All online requests for prescriptions went straight to the lead GP to process. We undertook a review of ten prescriptions issued within the preceding month and found an occurrence where a prescription was inappropriately printed. However this was picked up by the GP and was handled appropriately by the practice.

The IT system flagged up relevant medicines alerts when the GP prescribed medicines. We were told by staff that when a medicine alert was received on the system it was received by all clinical staff and cascaded down to administration staff to ensure full awareness. Medicine alerts that were relevant to the practice were discussed in both clinical and practice meetings.

Cleanliness and infection control

We observed that the premises were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us that they always found the practice clean and had no concerns.

All staff had received infection prevention and control training at their induction and update training was given within practice meetings.

We observed there to be fabric chairs in the waiting area, and some were torn with their foam filling exposed. The practice was aware of this issue and was in the process of replacing all chairs in the waiting area. There was carpet within some of the consulting rooms, which was clean and well maintained with no stains or tearing present. Cleaning schedules showed that the carpet and fabric chairs were deep cleaned on a monthly basis. The practice was also in the process of replacing the flooring in line with national guidance. However carpet could be placed in areas of the practice where there is a lower risk of spillage. The practice had not undertaken a legionella risk assessment.

An infection control policy was available for staff to refer to, which enabled them to plan and implement prevention and control of infection measures. For example the infection control lead carried out a monthly unannounced inspection, using the infection control checklist to ensure infection control standards were being kept. The result of the inspection was discussed with the GP partners and any remedial action taken. We viewed the latest inspection report carried out in September 2014 which highlighted the need to replace the fabric chairs in the reception area.

We found no evidence that the practice carried out legionella (a germ found in the environment which can contaminate water systems in buildings) testing, risk assessment or investigation.

Equipment

We checked the practice equipment maintenance records and found that all equipment had been checked and calibrated in January 2014. This included the calibration of thermometers and medicines fridge and the check of all hard wiring. We found no evidence of PAT testing for the electrical appliances.

Good

Are services safe?

Staff we spoke with told us that they had enough equipment to enable them to carry out diagnostic examinations, assessments, treatments and to maintain administrative records.

Staffing and recruitment

The practice had a recruitment policy and process which included the submission of an application form, pre-employment checks and interview process. We looked at staff records and found that references were not held on file. We were informed by the GP that verbal telephone references had been obtained however no record of the conversation had been placed on file. The recruitment policy stated that references would be obtained and the policy was not being followed. All staff had a Disclosure and Barring Service (DBS) check. This included all staff that undertook chaperone duties.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Each member of administration staff worked a three day week and arrangements were in place for staff to work extra hours to cover times of sickness, annual leave or high patient demand.

There had been very little turnover of staff with many members of staff working for the practice over five years. This enabled continuity of care with accessibility of appointments.

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 ensure patients were kept safe. However, the issue of more nurse cover being required was identified by the practice. The practice were responding to this by recruiting further nurses and training existing administration staff as healthcare assistants.

Monitoring safety and responding to risk

The practice had systems in place to manage and monitor risks to patients, staff and visitors to the practice. This included health and safety risk assessments and checks of the premises, medicines management and processes to deal with an emergency.

Risks identified through risk assessments were discussed between the health and safety lead and the lead GP. An action plan was developed and discussed in practice meetings. A recent discussion focussed on the panic buttons within the building and how they should be appropriately used.

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. We were not informed as to whether there were any processes in place for acute pregnancy problems. Examples were also given of how patients that were experiencing a mental health crisis were reviewed by the GP and referred to the local mental health team for an urgent mental health review. 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 monitored on patient record cards. We viewed minutes of meetings between the practice and the district nurse team that discussed the on-going 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. All staff had received basic life support training. Emergency equipment and medicines were available, including oxygen and defibrillator. All staff knew the location of the equipment which was kept in a locked facility with the key accessible to all staff. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All emergency medicines we checked were in date. We were assured that a full risk assessment had been undertaken and staff were aware of the protocol to deal with an emergency, including calling for an ambulance.

The practice had a business continuity plan to ensure they were able to continue to provide a service to patients. This included the transfer of urgent care appointments to the practice's Hendon site. Patients would be informed of this through an answer machine message. The document also contained what to do if there was a loss of the computer system and the loss of power.

A full fire risk assessment had been carried out and alarms were tested on a monthly basis. We saw records that showed staff to be up to date with fire safety training which included fire marshal training.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance including guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The latest best practice guidance was discussed on a monthly basis between GPs and nursing staff. We saw minutes of meetings where new guidelines were disseminated, the implications for the practice's performance and patient care were discussed and changes to practice agreed.

The staff we spoke with and evidence reviewed confirmed that changes in practice were to ensure that each patient was given the best support to achieve an effective health outcome. Each patient received an assessment and diagnosis in line with the most current guidelines. We viewed the minutes of clinical meetings where the needs of patients were discussed at and individual patient cases were reviewed to provide an up to date assessment when appropriate.

We were provided with copies of the monthly practice meetings were we found that best practice in relation to areas such as consent and patient confidentiality was discussed.

To ensure that patients who may be at a higher risk and needed a more detailed needs assessment were identified, a risk stratification tool was used. The tool identified the top 2% of a particular group, for example patients with a high attendance at accident and emergency (including older patients), long term conditions and those patients with mental health concerns. Best practice guidance would then be used to discuss these issues 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 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 regular reviews. We spoke with the manager of two care homes who confirmed that the practice undertook cognition testing annually and if any issues arose in the interim, the patient would be seen at the surgery. 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.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GPs and practice manager showed that the culture in the practice was that patients were referred on need, and that no other factors, such as age, sex and race were taken into account in the decision making process.

Management, monitoring and improving outcomes for people

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 is performing in line with the CCG average (96.22%) and the national average (96.17%) achieving 96.2%. 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's performance had been reviewed through some clinical audits undertaken by the principal GP. Audits included a review of patients with rheumatoid arthritis to determine the number of patients who had a face to face review in the preceding 12 months. The audit also reviewed the number of patients that had received a cardiovascular risk assessment as part of their review. The practice found that, in the patients audited, 100% of reviews for rheumatoid arthritis were completed, and 90% of reviews completed for those that received a cardiovascular risk assessment. The practice followed up on the patients who did not attend their review and planned to repeat the audit in 12 months (March 2015). The practice was unable to demonstrate any completed audit cycles where changes had been implemented and their impact reviewed.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 67% of patients with diabetes had received a flu

Requires improvement

Are services effective?

(for example, treatment is effective)

vaccination, and 71% of patients with chronic obstructive pulmonary disease (COPD) had received an annual review. The practice was not an outlier for any QOF (or other national) clinical targets.

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 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 mandatory courses such as basic life support. We found evidence in the minutes of practice meetings where complex conditions such as dementia and mental health were discussed to improve staff knowledge.

All GPs were up to date with their yearly continuing professional development requirements and had been recently revalidated. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

We found that there was a patient demand for more nursing staff. The practice was made aware of this through patient feedback and through their own review of the practice. The practice had addressed this by training administration staff as healthcare assistants and advertising for a further full time nurse.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. Staff told us that self-improvement was encouraged. If there was a gap in skills within the practice and a current member of staff showed interest, they were trained to fill that gap, for example a receptionist training to become a secretary and administrators being trained as healthcare assistants. The practice had a plan to ensure that those members of staff receiving a promotion were replaced through an active recruitment programme.

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.

We were informed that the practice had good working relationships with the palliative care team and local mental health teams. The practice had a history of working with the community midwives for the provision of maternity care within the practice but due to the lack of availability of midwives, this work was currently being undertaken by the practice nurse.

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 within nursing homes and children on the at risk register. The meetings were attended by staff from the care home, district nurses and social workers. 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 copies of the minutes for the last two meetings which provided a patient update and the action that was to be taken. Further meetings would be called in the interim period if the need arose.

Information sharing

The practice used the electronic Choose and Book system for making referrals. The system enabled patients to choose which hospital they wished to be treated in and book their own outpatients appointment in discussion with their chosen hospital. The practice also used a shared

Requires improvement

Are services effective?

(for example, treatment is effective)

system to share information with other health providers including the local out of hour's provider. However the practice did not have summary care records to share information with other health providers.

The practice had systems in place to provide staff with the information that they needed. This included an electronic patient record card which was used by all staff to coordinate and document treatment. The electronic card contained a complete medical history for the patient which was used as both a reference for the treating professional and also a tool to update current treatment. The software enabled all paper communications such as hospital letters to be scanned onto the electronic card. All staff had received full training in the system.

Consent to care and treatment

We found that clinical staff at the practice had received training in the Mental Capacity Act 2005 and the Children's and Families Act 2014. This training had been cascaded to other staff members through the practice meetings. 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 carer or the manager of the nursing home for patients with dementia. We were shown evidence of care plans which required consent and were counter signed by a family member as a witness. If the patient did not have any family, the signatory was the manager of the care home in which they reside. However we were not provided with any evidence that the practice assured themselves where third party consent was required that an appropriate person was identified.

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, in 2013, the practice vaccinated 87.3% for the MMR and the CCG average was 80.3%. The practice telephoned patients who did not attend for vaccinations as a reminder and to encourage to attend.

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, including support for the families of premature babies. The practice also operated a register of children at risk or in social services care and GP's 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.

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 undertaken annual reviews for 71% of patients on the practice COPD register. The reviews included a medicines check to ensure medicines were still relevant to the condition. The practice ran a nurse led clinic for bronchitis which was identified as a local health concern. Smoking status was added to patient records and smoking cessation classes were run on an ad hoc basis. The practice was unable to provide data regarding quit rates. The practice proactively monitored patients who may develop 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.

The practice held a register of patients with poor mental health of which currently 78% 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. However only 40% of patients on the register had received a depression review with no

Requires improvement

Are services effective?

(for example, treatment is effective)

evidence of this being followed up. The practice worked with care homes 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 GP's provided regular health reports for the meetings.

The practice had a 70% uptake for cervical screening. The practice was aware of this matter and were promoting this service within the practice and sending reminders to those patients that were due for the screen.

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

Health advice leaflets were available within the reception area or direct from the nurse. However leaflets were only available in English.

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 happy with the service they received and they were listened to by staff and treated with respect. Data form the national GP patient survey showed that 79% of patients said the last nurse they saw or spoke to was good at treating them with care and concern, which was above the Clinical Commissioning Group (CCG) average of 71%. The survey also showed that 79% said that the last GP they saw was good at giving them enough time which was below the CCG average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 26 completed cards and the majority were positive about the service experience. Patients said they were listened to by the staff and felt involved in planning of their treatment and that the environment was clean and safe. Five of the comment cards were less positive and stated that it was difficult for them to get through on the telephone system to make an appointment. This was an issue the practice was aware of and was putting a system in place to improve the access.

We also spoke with ten patients on the day of inspection, who were happy with the 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 consulting room was left free at all times in case a patient wished to talk to a member of staff in private before their consultation.

Staff told us that if they had any concerns or observed any discriminatory behaviour they would raise these with the practice manager who would investigate the circumstances. We were provided with an example of where a patient was abusive towards staff and asked to leave by the practice manager. This incident was discussed within the practice meeting where learning through the discussion of the event had taken place.

We found that the practice had a culture of ensuring that patients were treated equally. Therefore those patients with mental health concerns or in vulnerable conditions 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 74% of patients said that the GP was good at involving them in their care, and 83% said that the GP was good at explaining test results and treatments, which were both weighted above the Clinical Commissioning Group (CCG) average. The results from the practice's own satisfaction survey showed that 86% of patients said they were sufficiently involved in making decisions about their care. The national patient survey also showed that 69% of patients said that the nursing staff were good at involving them in their care which was above the CCG average of 58%.

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 listened to and supported by staff to make an informed decision about the choice of treatment they wished to receive.

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 of they required a translator; however we did not see notices in the reception areas informing patients that the service was available.

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

Good

Are services caring?

provided by the practice. People told us that when they needed emotional support the GP would go out of their way to offer support through providing an appropriate referral to another service or by providing information of how they could access relevant support groups. We viewed information within the reception area for groups that offered external support.

The practice had a carer's policy and the practice computer system alerted GPs if a patient was also a carer. We were 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 that the practice was responsive to patient needs and had a system in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to ensure that the practice remained current to the local population needs. The practice used a risk stratification tool provided by the Clinical Commissioning Group (CCG) to identify patients that were more at risk to plan services and prevent unwanted patient outcomes, for example inappropriate attendance at accident and emergency. The tool allocated a risk score to patients dependent on the complexity of their health concerns, with more resources being allocated by the practice to those at the higher end of the risk spectrum.

Longer appointments were available for patients who requested them. Those with long term conditions, mental health concerns and vulnerable patients were able to book appointments at quieter times of the day. Elderly patients and those who were vulnerable were able to access an appointment with their named GP when required and had access to a second specific telephone number which gave access to the GP for appointments and telephone consultations.

Home visits were made to three local care homes each week. We spoke with the managers of the homes who were all happy with the service provided. Daily home visits were also made to those patients that telephoned the practice and requested one by the lead GP. Out of hours appointments and telephone consultations were available for patients who worked.

A register was held which identified those older people who were high risk of admission to hospital or at the end of life. We reviewed care plans that were kept up to date and shared with other health providers. The practice provided a follow up consultation to patients that had been discharged from hospital if there was a need. The practice currently followed up all patients discharged to care homes, and was implementing a system of follow up for all patients on the practice risk register. Patients over 75 were provided with a named GP and a direct telephone line to bypass the main appointments switchboard.

A register of those patients whose circumstances make them vulnerable was held. Those patients with a learning disability were offered longer appointments to give time to discuss health concerns. All patients with a learning disability received an annual follow up and health check.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss patients and their families care and support needs.

The practice Patient Participation Group (PPG) met on a quarterly basis and discussed the need of the patient population and raised specific issues with the practice. At a recent meeting the issue of the development of the practice website was discussed. We were informed that the practice work well with the PPG and all suggestions for service improvement were considered. Examples of recent suggestions that had been taken on board and implemented included the development of an online appointments system and the introduction of an electronic prescription service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its service. For example for those patients with "no fixed abode", temporary registration with the practice was offered and patients were not required to provide proof of address in order to be able to register with the practice.

The practice had access to a telephone translation system which could be booked for consultations. The practice did not provide written literature in alternate languages to English. However the practice was investigating ways to provide this service. One area they looked at was translating via the internet but this was deemed to be unreliable as there could be too many inaccuracies.

The premises was fit for use by those people with a physical disability and those patients with push chairs with a consultation room being left free on the ground floor at all times. If needed, the GP would relocate to that consultation room to enable better access to the service and so that the patient could avoid using the stairs to the second floor.

The practice actively supported people who had been on long term sick leave to return to work by the use of the 'fit note' and a phased return to work.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 8am to 8pm on a Monday, 8am to 6.30pm on a Tuesday and Thursday, 8am to 1pm on Wednesday and 7am to 6.30pm on Friday. Late appointments on Mondays and early appointments on Fridays were available for patients who worked. The practice was closed to patients on a Wednesday afternoon for training and administrative duties to be undertaken by clinical staff, however if a patient presented at the practice as an emergency, the GP would provide a consultation. The GP also provided telephone consultations at the end of a session and home visits for those patients unable to attend the practice.

Information was available to patients on the practice website and in the patient leaflet. This included how to arrange routine and urgent appointments through the practice appointment system and how to contact the out of hour's provider. There were also arrangements in place to ensure patients received medical assistance when the practice was closed. If patients called the practice when it was closed, the practice answer machine directed them to a local walk in centre or out of hour's provider. The practice ran an online booking system which was accessed through the practice website. The practice offered a text message reminder system to those patients who registered their mobile telephone number. This provided appointment reminders and if booking online, a confirmation of that booking.

The practice's extended hours on Friday mornings and Monday afternoons were particularly useful to patients with work commitments. This was confirmed by patients stating that they were happy that they could make see their GP before going to work and that it gave the flexibility to see the GP around their working hours. The practice had recently installed an electronic prescription service which meant that patients could request a repeat prescription online, which was authorised by the GP and sent to the pharmacy for collection.

Patients we spoke with were generally satisfied with the appointments system however concerns were raised through patient feedback of the inability to get through to the practice on the telephone. The practice responded to this by the installation of a new telephone system and the development of a new telephone booking system which was in the early stages of implementation and had not been audited to evaluate what effect it had on patients being able to make an appointment.

Listening and learning from concerns and complaints

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

We found that the complaints procedure was available to help patients understand how to make a complaint and was displayed in the reception area. Patients we spoke with were aware of the procedure but had never needed to make use of it.

We looked at five complaints received in the last 12 months and found all to be responded to appropriately and in line with the practice procedure.

The practice reviewed complaints on an annual basis to detect themes and trends. We looked at the report for the last review and found that complaints had mainly been received regarding the appointments system. The appointments system was an area that the practice was implementing changes. We also viewed minutes of practice meetings which showed where complaints had been discussed and lessons learned.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care to its patients. We found details of the practice vision, values and plan for the next five years. The practice's values were discussed and shared with all staff and clearly displayed within the practice. The practice vision and values included the growth of the patient list to 10,000, to provide more in house services, to become integrated with local networks and to work closely with other local practices.

We spoke to three members of staff who were aware of and shared in the vision of the practice. We viewed a display within the practice meeting room from the staff working group which developed the five year plan and saw where all staff had played a part in the development of the vision and values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity which was available to all staff on the computer system. A policy folder was also available in the administration office. We viewed five policies and found them to be relevant to the operation of the practice. All the policies had dates indicating when they were last reviewed, and when their next review was due. The policies we reviewed were due for next review in March 2015. Responsible persons were assigned to all areas of governance within the practice.

Governance was discussed at regular clinical meetings. We reviewed recent minutes of the clinical meetings and found that ways of improving performance and minimising risk within the practice was discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. This data showed that it was performing in line with national standards. QOF data was discussed at practice meetings and ways to improve performance was discussed. One matter discussed at a recent clinical meeting was how to increase the number of diabetic check-up appointments through the employment of more healthcare assistants and nurse cover.

The practice had completed a number of clinical audits which included a review of patients with rheumatoid arthritis to determine the number of patients who had a face to face review in the preceding 12 months. The audit also reviewed the number of patients that had received a cardiovascular risk assessment as part of their review and an audit of rheumatoid arthritis patients who had received a review. However we found that audit cycles were incomplete and the practice was unable to demonstrate where changes had been implemented and their impact reviewed.

The practice had arrangements for identifying, recording and managing risks. We saw the practice risk log which identified potential issues such as broken chairs in the waiting area, carpets in the consulting rooms and the placement of panic buttons. We saw that the risk log was regularly discussed at meetings between the lead GP and the practice manager and an action plan was produced to enable a reduction in the risk for patients and staff.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example the GP was the lead for safeguarding and the practice nurse was lead for infection control. Each of the GP's also had clinical responsibility for areas such as paediatrics, diabetes, gynaecology and mental health. We spoke with six members of staff who were clear about their role and responsibilities. They also said that they felt valued and supported by the management and knew that they could go to a member of the management team for advice and support if it was required. Staff told us that there was an open culture and all felt happy to raise concerns in practice meetings. A slot was reserved on every agenda for staff to raise concerns.

The practice manager was responsible for the human resources policies and procedures. We were shown a number of related policies, including the induction policy, staff training policy and absence policy, which were in place to support staff. All policies that we viewed were in date and had a review date present. Staff we spoke with knew where to find the policies on the computer system 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. We looked at the results and patients raised concerns regarding access to the surgery

Are services well-led?

Good

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

over the telephone. The practice responded by installing a new telephone system to improve access and was in the process of improving the telephone booking system and developing the online appointment booking system.

The practice had an active Patient Participation Group (PPG) with 20 patient representatives from all of the patient population groups. The PPG met every three months, with the practice management team to discuss issues of concern, organise the annual patient questionnaire and provide logistical support during flu vaccination days. The practice had produced an action plan with the PPG which included the update of the telephone system, development of the practice website, update of practice newsletter and online prescription requests.

The practice gathered feedback from staff through staff meetings and annual appraisal discussions. Staff told us they were comfortable in giving feedback to the practice manager and GP and were happy to discuss issues with colleagues and management. Staff told us that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff on the shared computer system and in the policy folder located in the administration office. Staff we spoke with were aware of the policy and where it was held but had not used the policy.

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.

The practice had completed reviews significant events and other incidents and shared the information and outcomes with staff during practice meetings to ensure the practice improved outcomes for patients. For example, following an incident when vaccines were left in the reception area over the weekend period and had to be disposed of as they had not been stored properly, the correct procedures to be followed to ensure vaccines were maintained at the correct temperature was reiterated to all staff and the relevant policies updated.