Alexandra Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Alexandra Medical Centre on the 5 May 2015.

Overall the practice is rated as good. Specifically we found the practice to be good in providing care that was safe, effective, caring and responsive and well led. It was also good for all population groups.

Our key findings were as follows:

- The practice had robust arrangements in place to ensure patients received a safe service. Risks to patient safety were effectively managed. The practice investigated, acted upon and learnt form incidents that occurred.
- The practice was effective in providing positive outcomes for patients. Patient care was provided by staff who had received appropriate training. The practice worked with other health and care providers to deliver co-ordinated care.
- Patients we spoke with told us that staff provided a caring service. They us that they were treated with dignity and respect, their privacy maintained and that staff were friendly and helpful.
- Practice staff responded to the various patient groups and tailored care to meet patient's needs. GPs carried out clinical audits and made changes to patients care and treatments to ensure best practice. Information and feedback from patients was used to promote good systems of care.
- Practice staff had a clear vision to deliver high quality care and promote good outcomes for patients. This was evident when speaking with patients and staff during our inspection. Staff had lead roles and responsibilities and were supported in carrying out their roles effectively.

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 was rated good for providing safe services. There were systems in place to investigate and address incidents and to protect children and vulnerable patients from risks of harm. Patients we spoke with told us they felt relaxed and comfortable with practice staff during their visits to the practice and that they had confidence in staff. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. They took action to learn from incidents and made appropriate safeguarding referrals when required. Senior staff used robust recruitment practices and checks had been carried out before staff commenced working at the practice.

Are services effective?

Good

The practice was rated good for providing effective services. The practice took account of clinical guidelines such as National Institute for Health and Clinical Excellence (NICE) when providing care. Patients' needs were assessed and care was planned appropriately to meet their needs. Appropriate arrangements were in place to identify, review and monitor patients with long term conditions and specialist needs. Multidisciplinary working was evident to ensure patient needs were appropriately met. Staff received training appropriate to their roles to ensure their skills and knowledge were kept up to date. Staff appraisals were carried out and personal development needs identified. Health promotion and prevention was carried out within the practice.

Are services caring?

Good

The practice was rated as good for providing caring services. Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Patients told us they were satisfied with the care they received. There were arrangements in place to provide patients with end of life care that was compassionate and respected patients' needs and wishes. Accessible information was provided to help patients understand the care available to them. We observed staff treating patients with kindness and respect whilst ensuring their confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients were given opportunities to comment on the way care and treatment was delivered by GPs. Practice staff demonstrated how they listened to and responded to their patient group. Practice staff

Summary of findings

had initiated positive service improvements for their patients. The practice had appropriate facilities and was well equipped to assess and treat patients in meeting their needs. Patients with mobility difficulties were able to access the practice. There was a system in place which supported patients to raise concerns and complaints. Complaints received were recorded, investigated and responded to appropriately.

Are services well-led?

Good

The practice is rated as good for being well led. All staff worked closely together to promote continuous improvements. There was strong leadership with a clear vision and purpose. All staff were encouraged and involved with suggesting and implementing on-going improvements that benefitted patients. There were appropriate arrangements in place to effectively manage risks. Staff had identified the need for change and made improvements that benefitted patient care and treatment. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Practice staff actively sought feedback from patients and the Patient Participation Group (PPG). PPGs are a way for patients and practice staff to work together to improve services and promote quality care.

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. Patients aged over the age of 75 years had been informed of their named and accountable GP. All older patients had received annual health checks and where necessary, care, treatment and support arrangements were implemented. The practice offered proactive, personalised care to meet the needs of older people and had a range of enhanced services including avoidance of unplanned hospital admissions. The practice was responsive to the needs of older people, including offering rapid access appointments or home visits for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Practice staff recognised the long term condition needs of its practice populations. They held a register of patients who had long term conditions and carried out regular reviews. GP's worked with relevant health and care professionals to deliver a multidisciplinary package of care. Clinical staff had good working relationships with a wide range of community staff and held regular meetings with them to ensure patients received seamless care. A diabetes specialist visited the practice each month to review those patients with complex needs. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. Practice staff supported patients and carers to receive co-ordinated, multidisciplinary care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours four evenings per week and the premises were suitable for children and babies. Practice staff liaised with local health visitors to offer a full health surveillance programme for children. Checks were also made to ensure maximum uptake of childhood immunisations. The clinical team offered immunisations to children in line with the national immunisation programme. There was a safeguarding policy in place for children and adults that included principles and definitions of the different types of safeguarding concerns. The GP who was the lead for safeguarding and all other staff had received appropriate training.

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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). Community midwives held regular ante natal and post natal clinics at the practice. The practice offered extended opening hours to assist this patient group in accessing the practice. Opening times were until 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays and until 1pm on Thursdays. Appointments were available from 8.30am until 12pm and 4pm until 6.30pm with the exception of Thursdays. Patients who needed to be seen on the same day but were unable to book an appointment were given the option of waiting and being seen at the end of morning clinics. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk of harm.

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. Practice staff had identified patients with learning disabilities and treated them appropriately. Practice staff regularly worked with multi-disciplinary teams in the case management of vulnerable people. All patients within this group had received annual health checks. GPs carried out regular home visits to patients who were unable to access the practice and to other patients on the day they had been requested. The practice provided an enhanced service to avoid unplanned hospital admissions .This service focused on coordinated care for the most vulnerable patients and included emergency health care plans. The aim was to avoid admission to hospital by managing their health needs at home. An enhanced service is a service that is provided above the standard general medical service contract (GMS).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). There was an average prevalence of patients with mental health issues. Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to patients with serious mental health illnesses. GPs had the necessary skills and information to assess and treat or refer patients with poor mental health. A community psychiatric nurse visited the practice every week to see patients who experienced mental health problems. Practice staff had recognised the need and provided health checks and support for patients who had dementia.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection who varied in age. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all gave us positive feedback about the standards of care they received. Patients told us it was easy to obtain repeat prescriptions and book appointments.

We collected 11 patient comment cards on the day of the inspection. Positive feedback was given by most patients who had made written comments. They included standards of care, ability to book appointments, that staff were caring, friendly, listened, were responsive and the overall patient experience was positive. We received some negative comments about ability to book appointments.

We looked at results of the GP patient survey dated 2015. Findings of the survey were based on the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The latest results were:

- 66% of respondents would recommend the practice, the local CCG average was 76%,
- 61% were satisfied with the opening times, the local CCG average was 77%,
- 73% felt it was easy to get through by telephone, the local CCG average was 70%,
- 73% had good or very good experience for making an appointment, the local CCG average was 71%.

The practice had a Patient Participation Group (PPG). PPGs can be an effective way for patients and practice staff to work together to improve services and promote quality care. We spoke with three members of the PPG including the lead person. They told us they were influential in encouraging the practice to review and make improvements and that practice staff responded positively to suggestions. For example, provision of hand hygiene gel at the reception desk for patients to use.

Alexandra Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a specialist advisor who had experience in practice management and an expert by experience who had personal experience of using primary medical services.

Background to Alexandra Medical Centre

The practice provides primary medical services to approximately 2650 patients in the local community. Practice staff told us there that 60% of patients are of ethnic origin with a high proportion of patients originating from Yemen and Asia.

There is one male and one female GP partner in this practice. This helps to ensure that patients can book an appointment with a female or male GP if they prefer. There is also a locum GP who works every Tuesday evening. Two practice nurses assist GPs with care and treatments patients require. The practice manager is supported by an office manager, two receptionists and an apprentice receptionist who works varying hours.

The practice has a General Medical Service (GMS) contract. This is a contract between NHS England and the general practices for delivering general medical services and is the commonest form of GP contract.

The practice offers a range of services including, asthma, child health and development, contraception, chronic obstructive pulmonary diseases (COPD) and minor surgery.

The practice opening times are 8am until 6.30pm Mondays, Tuesdays, Wednesdays and Fridays. The practice closes at 1pm on Thursdays. Appointments were available from 8.30am until 12pm and 4pm until 6.30pm with the exception of Thursdays.

The practice has opted out of providing out-of-hours services to their own patients. This service was provided by Primecare an external out of hour's service contracted by the CCG.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

- 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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 5 May 2015. During our inspection we spoke with a range of staff including two GPs, a practice nurse, practice manager, the office manager, two receptionists and the apprentice receptionist. We spoke with eight patients who used the service and observed, how patients were being cared for and staff interactions with them. We looked at care and treatment records of patients. Relevant documentation was also checked. Patients had completed 11 comment cards giving their opinion about the service they received. We spoke with three members of the Patient Participation Group (PPG) who told us their experience not only as a member of the PPG but also as a patient of the service. The PPG is a way in which patients and the practice can work together to improve the service.

Good

Are services safe?

Our findings

Safe Track Record

We spoke with eight patents about their experience at the practice. None of the patients we spoke with reported any safety concerns to us.

Practice staff used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. An incorrect entry into patient records was noted and corrected. To prevent similar occurrences a caution note was added to patients records that had similar names and patient numbers. The management team, clinical and non-clinical staff told us that they discussed significant events at a range of monthly staff meetings so that all relevant staff learnt from incidents and reduced the likelihood of recurrences.

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

Learning and improvement from safety incidents

There was a system in place for reporting, recording and monitoring significant events. Practice staff had identified a delay in the summarising of a newly registered patient's notes. An auditable system was implemented to ensure that notes were summarised in date order to prevent future delays.

Clinical staff spoken with confirmed that significant events, incidents and complaints were discussed at their regular monthly practice meetings and they were able to give some examples. This was confirmed from the minutes of the meetings that we saw. All staff were invited to attend these meetings.

National patient safety alerts were disseminated by the practice manager to relevant staff to read and sign off. Safety alerts were discussed at practice and multidisciplinary meetings to ensure all were aware of any that were relevant to the practice and where action needed to be taken. All practice staff spoken with knew where patient safety alerts were kept.

Reliable safety systems and processes including safeguarding

The practice had a lead GP for safeguarding vulnerable adults and children. All clinical staff had had been trained to the appropriate level in safeguarding to enable them to fulfil their roles. Practice training records made available to us showed that all non-clinical staff had received relevant role specific training on safeguarding.

Staff we spoke with were aware who the lead was and who to speak with if they had concern about patient safety. We saw that there were policies regarding the protection of vulnerable children and work had commenced on developing a policy regarding vulnerable adults.

Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and were aware that they should contact the relevant agencies in or out of hours. Contact details of agencies were easily accessible to staff.

Community staff including health visitors were invited to attend regular meetings so that patients who were considered to be at risk could be discussed. There was close co-operation with health visitors which helped to identify children at risk and keep them safe. An alert was included on the patient's file of those who were at risk so that they could be easily identified.

We saw that a chaperone policy was in place. Chaperone duties were usually undertaken by nursing staff. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. Although all non-clinical staff had received training in chaperoning duties only the lead receptionist carried out this role. They demonstrated an appropriate understanding of the role. A Disclosure and Barring Service (DBS) criminal record checks had been carried out for one non-clinical staff. There were risk assessments in place for other non-clinical staff that confirmed they did not require DBS checks. We saw a chaperone notice was displayed in the

waiting area and at regular intervals on the electronic patient display screen in the waiting area. Some patients we spoke with were aware that they could have chaperone if needed.

Medicines Management

Patients were able to order repeat prescriptions on line, by fax, by email, in person or via their local pharmacy. Patients we spoke with said they were happy with the system. There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

We found that vaccines were stored within the recommended safe temperature range in a lockable fridge. Temperature checks were taken and recorded each day. Medicines were kept safely within locked cupboards.

Emergency medicines were stored in a locked cupboard. We saw recordings that confirmed they had been checked regularly to ensure they were still in date and safe for administration. We saw that they were stored appropriately and were in date. We were told that GP's carried medicines in their bags for visiting patients in their home. The contents of the bags were checked monthly by a practice nurse to check the medicines remained in date and safe for administration. We were shown records that confirmed this.

Cleanliness & Infection Control

All areas of the practice were visibly clean and tidy. All patients we spoke with told us they had no concerns about cleanliness or infection control. They also told us that staff always washed their hands prior to carrying out procedures. There was a cleaning schedule in place for cleaning staff to follow.

All staff had received training in infection control.

Practice staff had carried out annual in depth infection control audits. The latest one was dated October 2014. The overall result was rated 98% and two actions were required. They were cleaning the door furniture and implementation of colour coded cleaning items. We saw that both of these actions had been addressed.

Once only disposable instruments were used for minor surgery and also for parts of medical equipment that came into contact with patient's skin.

An infection control policy and supporting procedures were available for staff to refer to including needle stick injury; which enabled them to plan and implement control of infection measures. For example, PPE including disposable gloves, aprons and coverings for examination couches were available for staff to use. Staff confirmed there were always good stocks of PPE available within the practice.

Each consulting room had dated disposable privacy screens, cleaning wipes, hand washing instructions and hard surface cleaning spray.

We saw posters at the wash hand basin advising patients and staff not to drink the water. We asked the practice manager how they supplied water for patients who became ill whilst they were in the practice. They told us they kept a supply of bottled water.

Equipment

We saw all equipment had been tested and that the provider had contracts in place for annual portable appliance testing (PAT).There were arrangements in place for routine servicing and calibration, where needed, of equipment such as blood pressure cuffs, weighing scales, and blood pressure monitoring equipment.

Staffing & Recruitment

There was an up to date recruitment policy that covered all aspects of staff recruitment. We looked at a sample of personnel files for a range of staff. Some staff had been employed at the practice for several years. We saw that a complete work history was obtained, evidence of identity, references and a Disclosure and Barring Service (DBS) criminal record checks had been carried out for all clinical staff and one non-clinical staff member. We were told a practice nurse had a DBS check when they commenced work at another practice but they did not have one for this practice. The practice nurse was recruited October 2014. Two days after our inspection the practice manager informed us that they had made an application for a DBS check for the practice nurse.

The professional registration status of all clinical staff had been regularly checked with the General Medical Council (GMC) for GPs and the Nursing and Midwifery Council (NMC) for nurses to ensure they were fit to practice.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. GPs provided some

Good

Are services safe?

cover for each other by working extra sessions and they used locum GPs when necessary. A locum GP worked regularly each Tuesday by covering the evening session. Nursing staff arranged patients' appointments around their annual leave dates. Non-clinical staff worked extra shifts and they rearranged their administration work to release staff to cover reception. The practice manager told us they would provide cover for reception if necessary.

Monitoring Safety & Responding to Risk

Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in an emergency. A fire safety risk assessment was in place and had been reviewed annually to ensure it was still relevant.

We saw that fire escape routes were kept clear to ensure safe exit for patients in the event of an emergency.

There was a health and safety policy in place and staff knew where to access it. Staff we spoke with demonstrated appropriate knowledge regarding health and safety.

Arrangements to deal with emergencies and major incidents

All staff at the practice had received training in medical emergencies such as basic life support on 20 October 2014. The practice had a defibrillator on standby for dealing with medical emergencies. An Automated External Defibrillator (AED) is a portable electronic device that analyses life threatening irregularities of the heart and is able to attempt to restore normal heart rhythm. It was checked regularly to ensure they were fit for purpose. The senior GP told us they had placed an order for a cylinder of oxygen. This may be needed during medical emergencies.

Emergency medicines and equipment were kept in clinical rooms and staff knew where they were stored. We saw information that confirmed they were regularly checked and that the medicines remained in date and fit for administration.

A medical emergency had occurred in the practice in March 2015. The practice manager told us this was discussed during a practice meeting to check whether any changes needed to be made and to ensure appropriate staff knowledge.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and actions recorded to reduce and manage the risk. Risks identified included power failure, computer failure, and access to the building. Areas of responsibility for staff were identified along with risks and actions recorded to reduce the risk. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with were able to describe how they accessed and implemented guidelines based on best practice such as National Institute for Health and Care Excellence (NICE) standards. NICE provides national guidance and advice to improve health and social care. To keep up to date with guidance the GPs told us that they attended meetings and appropriate training courses and read relevant literature.

We were told that the computer system included 'flags' to alert staff if a patient was also a carer of a patient and for those patients on the practice's palliative care register. This information was useful to ensure that staff were able to provide the level of support required and signpost patients to appropriate services if required.

The minutes of the multidisciplinary meetings told us that hospital admissions were regularly discussed to identify where changes could be made that may prevent admissions. Patients on the palliative care register were also discussed to ensure they received appropriate and integrated care.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with clinical staff showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Performance information on patient outcomes was available to staff and the public, which included monitoring reports on the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. QOF targets were reviewed regularly and we saw evidence of satisfactory QOF achievement. For example, there was 100% achievement for reviews of patients who had heart problems, cancer and palliative (end of life) care patients. The practice had exception reporting of 2.3%, which was 3.2% below the local Clinical Commissioning Group (CCG) average. Exception reporting is the exclusion of patients from the list who meets specific criteria. For example, patients who choose not to engage in screening processes. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

There was a system in place for carrying out clinical audits. One audit concerned reviews of all patients who were prescribed a specific medicine. The results were that some patients had their medicine dosage changed. This had resulted in improved patient treatment.

Another audit resulted in a risk register being set up for a specific condition and this audit was under continual review. Practice staff demonstrated that full audit cycles were in place.

All patients who required referrals were further reviewed by a GP to ensure they were necessary. Where possible referrals were made to community organisations rather than secondary care services. We were told this had resulted in fewer hospital referrals.

GPs were supported by a pharmacist who visited the practice regularly. The pharmacist provided advice about medicines that GPs prescribed for patients. We were not shown recordings that confirmed clinical audits concerning medicines had been carried out.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses.

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

All staff had annual appraisals that identified any learning needs from which action plans were documented. We saw that the practice nurses' appraisals were carried out by clinical staff. This was so that that their clinical practices and competencies could be discussed and appropriately evaluated.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, palliative (end of life) care teams and community nursing services to meet patients' needs.

Community nurses supported palliative care patients. We saw that records and care plans of patients who received palliative care were comprehensive. Regular meetings were held with the community matron, health visitor, mental health professionals and community nurses. We were told that Mcmillan nurses also attended these meetings. This promoted a partnership for ensuring patients received appropriate and integral care.

Midwives regularly attended the practice and held ante natal clinics.

There were systems in place to ensure that the results of tests and investigations from out of hours and hospitals were reviewed and actioned.

Patients were invited to contact the practice to receive their test results. However, if a test result was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information Sharing

The practice had opted out of providing out-of-hours services (OOH). This had been contracted by the CCG to an external service provider. There was a system for sharing relevant patient information so that the OOH service would be aware of any management needs while the practice was closed. The practice also received a summary for patients who had accessed the OOH service. These patients were reviewed and followed up where necessary by the GPs at the practice.

We saw evidence that the practice held multi-disciplinary meetings to discuss the needs of complex patients for example those with end of life care needs to ensure important information was shared. We saw joint working arrangements were also in place with the palliative care team quarterly.

The GP's we spoke with told us they had good working relationships with community services, such as community nurses and health visitors.

Regular meetings were held at the practice. All staff were invited to attend. Information about risks, accident and emergency attendances and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made. The management team attended Clinical Commissioning Group (CCG) meetings and information from these meetings was fed back to staff.

There was a practice website with information for patients about the practice. Information leaflets, and electronic screen and posters informed patients about local services were available in the waiting area.

Consent to care and treatment

The patients we spoke with told us they had been involved with decisions about their care and treatments. They told us they had been provided with sufficient information to make choices and were able to ask questions when they were unsure.

Patients who had minor surgery had the procedure explained to them and the potential complications before they signed the consent form.

GPs knew how to assess the competency of children and young people about their capability to make decisions about their own treatments. They understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. GP's demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

The practice manager told us all new patients were offered a health check by a practice nurse. New patients who were receiving medicines were given an appointment with a GP to review the medicine dosage and if it was still appropriate. We spoke with a patient who had recently registered with the practice who confirmed these arrangements.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw

Good

Are services effective?

(for example, treatment is effective)

some health and welfare information displayed in the waiting area. For example, breast screening, shingles vaccinations for patients aged 70 years and Macmillan nurses.

The practice was visited by an officer of Public Health on 13 January 2015. The purpose of the visit was to carry out an audit of vaccinations completed. The results were above average. For example, the practice had achieved a 78% uptake of shingles vaccinations for patients aged 70 years, the CCG average was 57%. Uptake for pneumococcal (pneumonia) vaccinations was 70% and the CCG average was 65% for this.

The practice offered a full range of immunisations for children in line with current national guidance. The uptake of vaccinations for five year old children was 91% and the CCG average was 95% for this.

The practice's performance for cervical screening uptake was 100% achievement. There was no exception rating for this. Exception reporting is the exclusion of patients from the list who meets specific criteria. For example, patients who choose not to engage in screening processes.

A range of tests were offered by practice staff including spirometry (breathing test) blood pressure monitoring and cervical smears to regularly monitor their health status. The practice nurse told us they gave advice to patients about healthy lifestyles when they visited the practice.

Health promotion literature was readily available in the waiting area.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with eight patients during our inspection. We received 11 completed cards where patients shared their views and experiences of the service. Patients we spoke with told us they felt that all of their health matters were assessed and they were cared for by staff who were considerate of their needs. Patients told us that staff displayed empathy and were respectful when they were in contact with practice staff.

We looked at results of the GP patient survey dated 2015. Findings of the survey were based on the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The latest results were:

- 71% of respondents said they saw or spoke with their preferred GP, compared with the CCG average of 58%,
- 94% said when they last seen by a nurse they were treated with care and concern, the CCG average was 90%.

We saw that staff treated patients with kindness and respect ensuring their confidentiality was maintained. Reception staff told us that a consultation room was always available if a patient requested private discussions.

Some patients we spoke with confirmed they knew their rights about requesting a chaperone. They told us this service was offered to them by clinical staff.

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

Care planning and involvement in decisions about care and treatment

Patients were encouraged to take responsibility for their health conditions and to be involved in decisions about medicines and other forms of treatments. They were empowered through discussions to acknowledge risks and make decisions about their treatments. All patients with complex needs or palliative (end of life) had care plans in place and these were regularly reviewed in line with patient's wishes. Patients we spoke with told us that clinical staff were good at involving them in making decisions.

Patients told us they were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. Patients we spoke with told us they were able to make informed decisions about their care and felt in control. The national patient survey reported that 90% reported that the nurse was good at involving them in decisions about their care, the local CCG average was 86%.

The Quality Outcomes Framework (3 May 2015) data informed us that in some areas the practice had exceeded the national target. For example, the practice had achieved 100% for contraceptive advice; the national target was 90% for this service. There was no exception rating for this area of clinical care. Exception reporting is the exclusion of patients from the list who meets specific criteria. For example, patients who choose not to engage in screening processes.

Patient/carer support to cope emotionally with care and treatment

The respective GP contacted bereaved families and offered a range of services they felt to be appropriate for the family to access. There were also bereavement counselling services available and a service called 'Healthy Minds' that GPs could make referrals to.

A GP told us that due to the culture of the population group they rarely agreed to provision of extra services because they relied on family support.

We saw information was on display in the waiting area for patients to pick up and take away with them. They informed patients of various support groups and how to contact them.

Practice staff held a carers register of people who provided care to others to enable staff to suggest ways of supporting them. There was information on display that advised carers where they could find help and support groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice delivered core services to meet the needs of the various patient population groups they treated. Registers were held for patients who had long term conditions, those who received palliative care and patients who were identified as being at risk. Patients were offered screening services for effective monitoring of patients who had long term conditions. For example, asthma, hypertension and diabetes. Staff had identified those patients who had a learning disability and all clinical staff had received training from a learning disability specialist nurse. We saw that all patients who were in this group had received annual health checks. The practice had a mental health register and those patients had received a health check.

Patients over the age of 75 years had an accountable GP to ensure their care was co-ordinated. All older patients were offered annual health checks. A phlebotomy (taking blood sample) service was not provided by practice staff. Patients visited the local hospital or another practice for this service.

Monthly multidisciplinary meetings were held to discuss patients and their family's care and support needs. We saw that all patients who were receiving palliative care were discussed to ensure they received co-ordinated care. Care plans were in place for patients who were at high risk of admission to hospital. A health visitor attended the meetings to review the needs of those patients who were at risk of harm.

A community psychiatric nurse visited the practice once a week to see patients who experienced mental health problems. A Clinical Commissioning Group (CCG) diabetes specialist carried out monthly sessions at the practice and saw those patients' with more complex diabetes. The practice manager told us they also worked alongside the practice nurse when they saw patients.

There was a male and female GP available at the practice which gave patients the option of receiving gender specific care and treatment.

The practice had a Patient Participation Group (PPG). PPGs are a way in which patients and practice staff can work together to improve the quality of the service. We spoke with three members including the chairperson of the PPG who told us the PPG made positive contributions to the service patients received. They told us they had requested a touch screen to enable patients to inform staff they had arrived for their appointment. This extra facility had been arranged by practice staff.

The latest practice patient survey report dated 2013-2014 was available from the practice website so that patients could readily access it. The results in the report were positive. For the questions asked the overall results were; 52% very good, 38% good and 10% was average. The report included action plans to address areas where the practice had scored less well. For example, the practice had increased its opening hours. The on line service was also established to enable patients to book appointments and request repeat prescriptions from their home. Progress against actions were discussed during each PPG meeting.

The practice was participating in the 'Friends and Family' survey. This involved patients completing a questionnaire and practice staff reported the results to the CCG each month. The results for March 2015 were; the number of patients who would be extremely likely to recommend the GP to others was eight, likely to recommend was one, neither likely nor unlikely was one, unlikely was two and extremely unlikely was two responses. These results were on display in the waiting area. The practice manager was monitoring the monthly results to obtain overall results of the survey.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where these had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. GPs and senior staff attended these meetings.

Patients we spoke with told us they were given choices about which hospital they wished to be referred to. They said that the GP would go through the system with them to assist them in making an informed decision.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services and had made arrangements for meeting their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

A GP told us that us that 60% of patients were of ethnic origin with a high proportion of patients originating from Yemen and Asia. Staff spoke Urdu, Persian, Kashmiri, Punjabi and French. The senior GP had learnt to speak Arabic to assist patients in understanding their health and care needs. Staff told us that translation services were available for patients who did not speak English as a first language. This service could be arranged to take place either by telephone or face to face.

The practice accepted temporary patients. They would initially be seen by a GP to assess if they had any urgent treatment needs.

The premises were accessible to patients who had restricted mobility. There was a toilet for people who had restricted mobility. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

The practice opening hours were 8am until 6.30pm each weekday except Thursdays when the practice closed at 1pm. Patients were able to access reception Thursdays afternoons to make appointments or be signposted to the out of hours service. Appointments were available from 8.30am until 11.30am and from 4pm until 6pm on Mondays, Wednesdays and Fridays and 6.30pm on Tuesdays. If the morning appointments were fully booked patients who wanted to be seen the same day were asked to wait until the end of the session when they would be seen by a GP. Reception staff told us that children and patients with poor health were always booked same day appointments.

Patients were able to book and order repeat prescriptions on line. This was useful for working age patients as well as those who had difficulty with their mobility.

Patients we spoke with told us they were able to book an appointment when they needed to. Two comment cards informed us they had problems in booking appointments at the appropriate times.

We asked some patients how long they usually waited when they arrived for their appointments. All responses told us patients were seen on time or shortly afterwards.

Patients were advised to use the local walk-in centre when the practice was closed or to contact NHS 111 if they needed an urgent appointment or to ring 999 in an emergency. This information was available in the waiting area, in the patient leaflet and via the practice telephone.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The 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 received by the practice.

The complaints procedure was on display in the waiting area. It included the contact details of NHS England and the local ombudsman if the complainant was not satisfied with the outcome of the investigation. On receipt of a complaint an acknowledgement letter would be sent to the complainant. An investigation would be carried out and a response sent to the complainant including any resultant actions that staff had taken to prevent similar recurrences. Practice staff we spoke with told us the outcome and any lessons learnt were discussed during practice meetings.

We saw the practice's log of complaints it had received. The review recorded the investigation details and outcome of each complaint and identified where learning from the event had been shared with staff.

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 an objective to provide quality care that met the population groups it served. The Clinical Commissioning Group (CCG) had agreed a practice development plan with senior practice staff. The document was dated March 2015. As a result improvements were being made such as longer opening hours. Senior staff had secured funding to extend the premises to improve patient access and facilities.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they felt an integral part of the team and were actively encouraged to make suggestions for making further improvements. The practice manager told us they would continue striving to improve the service.

Governance Arrangements

There was a clear governance structure at the practice that provided assurance to patients and the Clinical Commissioning Group (CCG) that the service was operating safely and effectively. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' and buying health and care services. There were clearly defined lead roles for areas such as safeguarding, a range of long term conditions and regularly checking that the clinical sessions met patient's needs. Responsibilities were equally shared between all respective staff.

We saw that monthly practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. All staff were encouraged to attend these meetings. Recordings were made of the meetings and any actions that arose from these meetings were clearly set out and reviewed to ensure required changes were made. Staff told us they could make suggestions for improvements and that they were treated as equals by senior staff. The meetings included strategy discussions and where improvements could be made for the benefit of patients. A receptionist we spoke with told us about their suggestions for improvement that had been implemented. For example, creation of a message folder for use by receptionists and an improved fax header.

The practice manager took an active role in overseeing the effectiveness and consistency of systems. GP partners were also proactive in that process. All policies and procedures that we saw had been regularly reviewed and kept up to date so that staff received appropriate guidance.

Leadership, openness and transparency

We saw that there was a clear leadership structure which had named members of staff in lead roles. For example, there were leads for infection control, safeguarding and for dealing with complaints. Staff were aware of lead roles and knew who to speak with if they needed any guidance or had concerns. Staff we spoke with were clear about their own roles and responsibilities and said that the practice manager and GPs could be approached at any time if assistance was required.

We saw evidence of staff appraisals that were regularly undertaken. Staff members we spoke with told us that they worked towards providing a good quality caring service.

Staff told us that they felt supported and also supported each other as necessary. We were told that staff worked well as a team and also that they felt appreciated for the work that they did.

Practice seeks and acts on feedback from users, public and staff

The practice had an active Patient Participation Group (PPG). PPG's act as a representative for patients and work with practice staff in an effective way to improve services and promote quality care. The PPG members told us they had been involved with discussions about improvements that were made following the results of the practice's patient survey. They told us that one member whose first language was not English fed information to their community group and provided information from them back to practice staff. For example, the reason for the poor uptake in child flu vaccines was due to a cultural issue. Practice staff had fed this information back to the organisation that was responsible for producing the vaccine with a view to making a change to the constituents of the vaccine.

We spoke with three members of the PPG. They told us practice staff worked as a team and the PPG had positive working relationships with staff. They informed us that staff

Are services well-led?

Good

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

made on-going efforts to improve the quality of the service and constantly searched for ways to improve staff practices. For example, the hand cleansing gel that was available at the reception desk for patient use.

The practice was participating in the 'Friends and Family' survey where patients were asked to record if they would recommend the practice to others. The survey commenced 1 December 2014 and the results were fed back to the CCG each month.

Management lead through learning & improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at some staff files and saw that staff appraisals included a personal development plan. Staff told us that the practice was very supportive of training and they were given time to attend training courses.

GP's held regular meetings to discuss each patient who had been admitted to hospital to monitor their progress and to determine if there were any lessons to be learnt. Minutes of meetings seen confirmed this. For example, a patient had been given confusing information about a blood test result. This led to the patient having to make an extra appointment. Systems were put in place to prevent a recurrence of a similar situation.

The practice had completed reviews of significant events and other incidents and shared them with staff through meetings to ensure the practice improved outcomes for patients. There had been nine recorded during the previous 12 months. For example, a patient reported they had not received the correct amount of prescribed medicines. The patient was informed that this was a matter for the dispensing pharmacy. The significant events had been analysed and where possible trends identified. An action plan was put in place for each type of event.