The Barnabas Medical Centre

Quality Report

Girton Road, Northolt, Middlesex, UB5 4SR
Tel: 020 8864 4437
Website: www.barnabasmedicalcentre.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?	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 a comprehensive inspection of The Barnabas Medical Centre on 21 January 2015. We rated the practice as 'Good' for the service being safe, effective, caring, responsive to people's needs and well-led. We rated the practice as 'Good' for the care provided to older people and people with long term conditions and 'Good' for the care provided to, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

We gave the practice an overall rating of 'Good'

Our key findings were as follows:

- The service was safe. We found infection control standards were followed, medicines were managed appropriately, safeguarding procedures were in place and there was sufficient staff to deliver safe services.
- Staff delivered effective care and treatment following professional guidelines.
- The practice worked with other health care professionals to manage patients with complex needs.
- Patients said they were treated with dignity and respect and they were satisfied with the overall service provided.
- Most patients were satisfied with access to the service and the appointment system. However, some patients fed back that the practice's opening hours could be improved.
- The practice had governance arrangements in place and staff were aware of who to report to with any concerns.

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

The provider should:

- Provide staff with access to and training in the use of an automated external defibrillator (used to attempt to restart a person's heart in an emergency) in accordance with the Resuscitation Council (UK) recommendations for primary care.

Summary of findings

- Ensure clinical staff complete basic life support training annually in accordance with the Resuscitation Council (UK) recommendations for primary care.
- Ensure staff complete fire safety training as part of their mandatory training requirements.

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.

Safety incidents were reported promptly, investigated and learning shared to minimise the risk of reoccurrence. Staff had received training in safeguarding children and adults and they were aware of the steps to take if they had any concerns. Systems were in place to ensure medicines were managed safely and infection control standards maintained. There were sufficient staff to keep patients safe and the necessary pre-employment checks had been carried out on staff. Although staff had been trained to respond to medical emergencies, clinical staff had not completed training annually in accordance with the Resuscitation Council (UK) guidelines. Plans were in place to deliver continuity of care during potential disruptions to services. Health and safety monitoring was being carried out and where risks were identified, control measures were in place to minimise them.

Are services effective?

Good

The practice is rated as good for providing effective services.

GPs carried out thorough assessments of patients' needs and these were reviewed when appropriate in line with professional guidelines. The practice had a system in place for completing clinical audit cycles and we saw evidence of improved outcomes for patients as a result. Staff were suitably qualified to deliver effective care and treatment and the practice worked with other health care professionals to deliver effective care to those patients with more complex needs. Consent was sought from patients when appropriate and staff had a working knowledge of key legislation such as the Mental Capacity Act 2005. The practice provided a range of health promotion services and had performed well in areas such as childhood immunisations and cervical screening.

Are services caring?

Good

The practice is rated as good for providing caring services.

Results from the 2014 national GP survey, the practices' annual satisfaction survey and feedback from patients during our inspection showed that patients were overall satisfied with the services provided by the practice and would recommend their GP practice to someone new in the area. Patients said they were treated with dignity and respect and they had confidence and trust in the

Summary of findings

practice team. The practice involved patients in decisions about their care and treatment and supported them through periods of illness or bereavement. Patients privacy was respected and their medical records were kept confidential and secure.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address these identified needs. The practice had recognised the needs of different groups in the planning of its services including those with learning disabilities, long-term conditions, poor mental health, older patients and children. Patients were overall satisfied with access however not all patients were satisfied with the practices' opening hours. The practice had a Patient Participation Group (PPG) and had made changes to the way it delivered services as a consequence of feedback from patients. The practice had a system in place for handling complaints and concerns and the system was working efficiently.

Are services well-led?

Good

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

The practice had a clear vision and governance arrangements in place. There was clear leadership and staff were aware of who they were accountable to and their level of responsibility. Regular meetings were held, staff were supported with training and their performance was monitored through annual appraisals. The practice gained feedback from staff and patients and acted on it to improve services. The practice used clinical audit to improve outcomes for patients.

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.

We found older patients were treated with dignity and respect. For example, longer appointments were available for older patients so they did not feel rushed. The practice offered a home visit service for those patients who were housebound. The practice had undertaken care planning for older patients and their care reviewed appropriately. Shingle vaccinations were proactively offered to older patients. Staff had completed training in recognising the signs of abuse in older patients and they were aware of the procedures to report any concerns. The practice worked with other specialists to provide effective care for older patients including end of life care.

People with long term conditions

Good

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

The practice provided longer appointments for patients with long-term conditions. Patients with a high risk score of hospital admittance were identified and set up on the clinical system in accordance with the unplanned admissions Enhanced Service (ES). These patients were reviewed on a regular basis and care plans developed for them. Patients with long-term conditions that were discharged from hospital were contacted and reviewed appropriately. The GPs lead on specific disease areas and they were supported by the nurse to deliver effective care.

Families, children and young people

Good

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

The practice prioritised children for appointments and always gave same day appointments to children under 5 years old. The practice provides both antenatal and postnatal care, a baby clinic for new mothers and childhood immunisations. All staff were trained in safeguarding children and were aware of the procedures to follow if they were concerned about a child's wellbeing and welfare.

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).

Summary of findings

The practice offered early morning appointments from 8:30am. Telephone consultations were available on request and the practice also offered health checks and registered patients who were away at university. Recently retired patients were encouraged to join the Patient Participation Group (PPG) to involve them in decisions about the running of the practice.

People whose circumstances may make them vulnerable

Good

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

The practice had a register of patients with learning disabilities and offered annual health checks and longer appointments for them. An interpreter service was available for patients where English was not their first language. A monthly meeting with local services was held at the practice with vulnerable patients on the agenda. Residents of a local homeless shelter were encouraged to register at the practice. Information was displayed in the patient waiting room signposting patients to local drug and alcohol services.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had a dementia register and patients on the register had received annual dementia reviews and medication reviews. Longer appointments were available for those patients with poor mental health. All mental health patients had a three to six month review as appropriate. Care plans were in place for patients with poor mental health and these were reviewed annually. Medication for mental health patients was not on a repeat basis so that the practice could monitor these patients closely.

Summary of findings

What people who use the service say

We spoke with four patients during the course of our inspection and two members of the Patient Participation Group (PPG). We reviewed two completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed the results of the practice's annual patient survey and the 2014 national GP patient survey. Patient feedback was overall positive about the practice. Patients were happy with the appointment system, the conduct of staff and their professionalism. Patients said that staff treated them with dignity and respect and the clinical staff listened to them, gave them enough time and involved them in decisions about their care and treatment. The results of the national patient survey where there was a 31% response rate (110 responses out of 359 surveyed), showed the practice scored above the local CCG average in terms of overall satisfaction with the practice, confidence and trust in the GPs, involvement in decisions about care and treatment and access to appointments. However, we did find the practice scored below the local CCG average in regard to opening hours. The results of the practice's latest annual patient survey where there was 552 respondents out of 8995 registered patients showed that that 76% rated the practice as 'excellent' or 'very good'.

Areas for improvement

Action the service SHOULD take to improve

Provide staff with access to and training in the use of an automated external defibrillator (used to attempt to restart a person's heart in an emergency) in accordance with the Resuscitation Council (UK) recommendations for primary care.

Ensure clinical staff complete basic life support training annually in accordance with the Resuscitation Council (UK) recommendations for primary care.

Ensure staff complete fire safety training as part of their mandatory training requirements.

The Barnabas Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to The Barnabas Medical Centre

The Barnabas Medical Centre is situated at Girton Road, Northolt, Middlesex, UB5 4SR. The practice provides primary care services through a Personal Medical Services (PMS) contract to 9200 patients in the local area. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of the NHS Ealing Clinical Commissioning Group (CCG) which comprises 80 GP practices. The practice serves a young transient population with the number of patients in the 25-40 age range above the England average. There are a high number of young patients and children under the age of 20 which is also above the England average. A high proportion of patients are of Polish origin. The practice staff comprise of four GP partners (two female & two male), and a salaried GP. The senior GP partner is also the chair of Ealing CCG. There are also three practice nurses, health care assistant, practice manager, assistant practice manager and a reception manager who is in charge of six reception/administration staff. The practice is a GP training practice and regularly has GP registrars undergoing training. The practice's opening hours are Monday to Friday 8:30–18:00 and patients are referred to NHS 111 services for out-of-hours care.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice provides a range of clinics and services including long-term condition reviews, cervical smears, minor surgery, travel advice and vaccinations, childhood immunisations, family planning, antenatal and Warfarin clinics.

The CQC intelligent monitoring placed the practice in band five. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 21 January 2015. During our visit we spoke with a range of staff including four GPs, a practice nurse, three reception/administration staff and the practice manager. We spoke with four patients who used the service and three members of the Patient Participation Group (PPG). We reviewed two comment 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. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a recent incident involved a patient receiving an inappropriate flu vaccine. This was because the patient had a condition that prevented them from receiving a live vaccine. The incident was recorded as a significant event and action taken to rectify the mistake and prevent its reoccurrence. The patient was prescribed an anti-viral medication and the incident was discussed with all clinical staff at the next meeting.

We reviewed safety records and incident reports and minutes of meetings where these were discussed since 2010. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice held records of significant events that had occurred since 2010. Significant events were a standing agenda item at practice meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and told us they were encouraged to do so.

We saw that incident forms were available on the shared drive of the practice computer system. We tracked three incidents that had occurred in 2014 and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, one incident involved problems with patients accessing a pathology service due to IT issues. The incident had been recorded and relevant IT professionals contacted to rectify the problem.

The practice manager told us that national patient safety alerts were disseminated via email to relevant staff and acted on. However, the practice were unable to provide us with any examples of safety alerts that needed to be acted on because none had been relevant to the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding children and adults. The GPs were trained to Level 3 in child protection, the nurses to Level 2 and non-clinical staff to Level 1. All staff had completed vulnerable adults training. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as the practice lead in safeguarding vulnerable adults and children. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments for example, children subject to child protection plans. A chaperone policy was in place and the policy was displayed in the consultation rooms. Chaperone training had been undertaken by the nurse and the health care assistant and non-clinical staff did not carry out chaperoning duties. All staff acting as chaperones had received a criminal check via the Disclosure & Barring Service (DBS).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were

Good

Are services safe?

disposed of in line with relevant regulations. Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. Repeat prescriptions could be ordered on the practice website or in person and were available within 48 hours. Prescriptions were managed appropriately. Patients we spoke with raised no concerns about the management of their prescriptions.

Cleanliness and infection control

Patients we spoke to did not raise any concerns with the standards of cleanliness and the practice was clean and tidy on the day of our inspection. A practice nurse and a GP shared the lead for infection control and were responsible for ensuring infection control standards were maintained. Clinical staff received infection control training annually and non-clinical staff every two years to ensure knowledge was kept up to date.

We saw evidence the practice had carried out infection control audits. We reviewed the latest audit undertaken in December 2014 and found that improvements identified for action had been completed on time. For example, clinical waste had been labelled correctly and hand gel replaced. The audit had been carried out by representatives from the NHS and was a requirement for practices carrying out minor surgical procedures.

An infection control policy was in place however the policy was not detailed and did not outline the infection control procedures staff should follow and who staff should report to with any concerns.

There was a procedure for staff to follow in the event of a needle stick injury and the procedure was displayed in the consultation rooms as a quick reference for staff. Soap dispensers throughout the practice had pictorial reminders of the correct hand washing technique for patients and staff to follow. Cleaning schedules were in place for both the clinical and non-clinical areas of the practice and the cleaning was carried out by a contract cleaning company. The nurse we spoke with was able to describe the routine for cleaning the consultation rooms between patients. Waste was stored appropriately and disposed of by a professional waste company.

The practice had an external company carry out a risk assessment for legionella (a germ found in the environment which can contaminate water systems in buildings). We saw evidence that the practice was monitoring the hot and cold water outlet temperatures on a monthly basis to ensure risks associated with legionella were minimised.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was January 2014. We saw evidence of calibration of relevant equipment completed in August 2014; for example weighing scales, fridge thermometers, blood pressure monitors, spirometers and vaccine fridges.

Staffing and recruitment

We looked at the recruitment records of a cross section of staff. The records contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements and we found locums were rarely used by the practice.

Good

Are services safe?

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Health and safety monitoring included a fire risk assessment, asbestos survey, infection control audits and a legionella risk assessment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified lead for health and safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support in the previous 18 months. However, clinical staff had not completed the training annually in accordance with the Resuscitation Council (UK) guidelines. Emergency equipment was available including access to an oxygen cylinder. All staff asked knew the location of this equipment and records we saw confirmed these were checked weekly. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and had not completed a risk assessment to identify and mitigate the risks associated with not having one available in the event of a cardiac arrest.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis (severe allergic reaction) and angina (chest pains caused by reduced blood flow to the heart). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and infectious disease outbreaks. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. All staff had access to the plan through the practice's computer system.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and local commissioners. Guidelines were accessible via the computer system for staff to view and updates were discussed amongst the GPs at clinical meetings. We saw meeting minutes where guidelines had been discussed such as those for the management of obesity. All the GPs were up to date with their continual professional development. We found from our discussions with the GPs that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, patients with complex needs and those with long-term conditions.

We found that the practice followed prescribing guidance from the Clinical Commissioning Group (CCG) medicines management team. For example, guidance for the use of medicines used in the treatment of dementia. The practice reviewed and discussed clinical guidelines with other practices through bimonthly network meetings. For example, guidance for the use of insulin in the management of diabetes had been discussed at a recent meeting.

The GP partners led in specific disease areas including diabetes, hypertension, chronic obstructive pulmonary disorder (COPD) and asthma. The practice nurses supported this work which allowed the practice to focus on patients with these conditions. Annual reviews were carried out on patients with long-term conditions in accordance with NICE guidelines.

The practice referred patients to secondary care and other community care services in accordance with national guidance including urgent two week wait referrals for suspected cancer. The practice had performed below the local average for referral rates for most conditions and accident & emergency attendances were also below average. However, we found hospital admissions for respiratory conditions were above average. A GP told us that the practice had investigated this and could not find a clear reason even when measures had been taken to reduce the number of referrals such as providing rescue packs to patients at home (medicines to be self-administered by COPD patients during an acute exacerbation of their condition).

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs 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

The practice had achieved 97% in their Quality and Outcomes Framework (QOF) performance in 2013/14 which was above both the local CCG and national averages and 75% so far in 2014/15. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. The four GP partners shared responsibility for QOF and the practices' performance was an agenda item discussed at meetings which helped the practice to focus on areas where services to patients could be improved. The practice had achieved 97.1% of the QOF points available in the clinical domains in 2013/14 and had maximised their points in the management of a range of conditions including asthma, cancer, dementia, heart failure and chronic kidney disease.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included the efficacy of medicines including those used in the treatment of diabetes, the management of cholesterol and osteoporosis. Three out of the five audits we reviewed were completed audit cycles in that the audits had been repeated to monitor improvement. We also saw a minor surgery audit carried out to review the standard of care provided to patients who had undergone minor surgical procedures. The results showed the practice was meeting the appropriate standards.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended mandatory courses such as basic life support, safeguarding children and adults, infection control and confidentiality. However, we found no evidence of staff training in fire safety and the practice fire marshal had not received fire marshal training since 2008.

Good

Are services effective?

(for example, treatment is effective)

A good skill mix was noted amongst the doctors with one GP having undertaken further training in diabetes and a second GP having a Diploma of the Royal College of Obstetricians and Gynaecologists (DRCOG). All GPs were professionally registered with the General Medical Council (GMC) and nurses with the Nursing and Midwifery Council (NMC). One nurse had an adult nursing postgraduate diploma and both nurses had completed specialist trading courses in areas such as asthma, diabetes, cardiology, insulin initiation, anticoagulation therapy, sexual health and contraception.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

An induction programme was in place for staff to complete when they started working for the practice. All staff undertook annual appraisals which identified learning needs and timelines for completion were documented. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service were received electronically. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and said the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings on a six weekly basis to discuss the needs of complex patients e.g. those with end of life care needs or children on the at risk register. These meetings were attended by the district nurse, palliative care nurses, the health visitor and community matron. The GPs also attended bimonthly network meetings with other local practices to discuss clinical cases and share best practice which was attended by a hospital consultant.

Information sharing

The practice had effective systems in place for referring patients to hospital and other health care professionals. Patients were referred to other services/specialists through the referral facilitation service (a central system where referrals are checked for appropriateness). We found the practices referral process was efficient and in line with national guidelines including two week wait urgent referrals for suspected cancer. Patient feedback showed they had no issues with the referral process. Patients said the GP's usually referred them in a timely manner and where offered a choice of where they would like to go.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff had been fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they would be implemented in their practice if needed. For example, when carry out mental capacity assessments on patients who lacked capacity to make their own decisions about their welfare.

GPs demonstrated an understanding of Gillick competencies (used to decide whether a child or young person 16 years and younger is able to consent to their own medical treatment without the need for parental permission or knowledge). A GP gave us an example of where a young person was appropriately assessed for the termination of a pregnancy without parental consent.

We saw examples of where GPs had documented consent for specific interventions. For example, written consent had been sought for the carrying out of minor surgery and scanned into patient's medical records. We also found consent had been sought for the use of chaperones and the sharing of patient information with 111 and other out of hour's providers. Training records showed that staff had received training in consent.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant or practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. The practice also offered health checks for patients aged 40 -75. We noted a culture amongst the GPs, nurses and the health care assistant to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and those with poor mental health. There were 13 patients on the learning disability register and nine had received annual health checks. We also found that all of the patients on the mental health register had received annual health checks.

The practice had achieved 98.4% of QOF points for cervical screening in the year 2013/14 which was above both the local CCG and national averages. At the time of our inspection the practice had so far achieved 77% of QOF points in the current year.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice was performing well for most childhood immunisations in comparison to the local CCG average. Other immunisations offered included HPV, Shingles and Pneumococcal.

The practice had administered flu vaccinations to 75% of patients over 65 years old in the previous year. At risk groups including those patients with COPD and diabetes and women during pregnancy were proactively offered vaccinations. The practice had achieved 90% coverage of at risk groups in the previous year.

Health information was displayed in the patient waiting room including lifestyle advice, sexual health services, vaccination programs and other general health advice.

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 2014 and the practices' annual patient satisfaction survey completed in 2014. We spoke to four patients during our inspection and also reviewed two Care Quality Commission (CQC) comment cards completed by patients prior to our inspection. The evidence from all these sources showed patients were overall satisfied with their GP practice. For example, the results of the national patient survey showed that 80% of respondents would recommend the practice to someone new in the area and this was above the local CCG average. This aligned with the practice's own survey where 76% of respondents rated the overall service provided by the practice as either 'excellent' or 'very good' and 97% would recommend the practice to family or friends. Patients we spoke with and comment cards received were also positive about the practice. National patient survey data showed that 96% of respondents had confidence and trust in the last GP or nurse they saw or spoke to which was above the local CCG average.

Patients we spoke with said that they were treated with respect, dignity and compassion by the practice staff and this was also reflected in the comment cards we reviewed. Patients said the care met their needs and staff were friendly and helpful. This evidence aligned with the national patient survey where 93% of respondents were happy with the helpfulness of receptionists, 91% said the last GP they saw was good at listening to them and 93% said the last nurse they saw was good at listening to them. All these results were above the local CCG averages.

We noted that patients' privacy was respected by reception staff and patients medical records were stored securely. Consultation room doors were closed to ensure that private conversations between clinical staff and patients could not be overheard.

Care planning and involvement in decisions about care and treatment

The results of the national patient survey showed that 91% of respondents said the GPs were good at explaining tests and treatments and 93% of respondents said the nurses were good at explaining tests and treatments to them. Eighty one percent of respondents said the GPs were good at involving them in decisions about their care and treatment and 87% of respondents said the same for the nurses. This was reflected in patient feedback during our inspection and comment cards received. Patients said that all clinical staff gave them enough time to explain to them their medical conditions and treatment options available. They also said the GPs gave them choices on referral to other health care professionals.

An interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

We saw examples of written consent sought from patients for the use of a chaperone, minor surgical procedures and the sharing of medical records with 111 and other providers of out of hour's services.

Patient/carer support to cope emotionally with care and treatment

Patients told us that staff were caring and supported them through periods of serious illness and bereavement. The GPs showed us how patients who were terminally ill and/or receiving end of life care were highlighted on the computer system to ensure staff were aware of patients requiring additional support.

Carer's were also highlighted on the computer system and carer's/patients notices in the patient waiting room and patient website signposted to support services such as Age Concern, Relate and the local IAPT (Improving Access to Psychological Services).

Information was available in the patient waiting room signposting patients to various support services. These included Age UK and the Alzheimer's society. There was also information on services for patients with dementia and their carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address these identified needs. The practice used the BIRT (Business Development & Reporting Tool), which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities. The practice used risk profiling to deliver a new unplanned admissions Enhanced Service (ES) which had been introduced to reduce unnecessary emergency admissions to secondary care. The requirements of the ES was to proactively manage 2% of at-risk patients over 18 years of age. At the time of our inspection the practice had completed care plans for 2.2% of those identified.

There had been very little turnover of GPs over the last few years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them and those with long-term conditions. This included appointments with a named GP for older patients, longer appointments for patients with learning disabilities and those experiencing poor mental health. The results of the national patient survey showed that 65% of respondents with a preferred GP usually got to see or speak to that GP.

The practice had a Patient Participation Group (PPG). The PPG was made up of approximately 20 active members and meetings were held every two months to discuss and feedback to the practice patients' views and opinions. There was also a facebook group for PPG members to communicate and discuss ideas online. We found that the PPG was not representative of all the practice's patient groups. However, the chair of the PPG was actively engaged in recruiting new members and was organising regular coffee mornings on a weekend to reach patients who were otherwise busy. The PPG was also involved in the analysis of the practices' annual satisfaction surveys and formulating action plans based on these. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. For example, the PPG had suggested a book exchange in the patient waiting room so patients could exchange books for free and this had been implemented. The PPG had also suggested a phlebotomy service at the practice however this had been put on hold due to lack of available clinical space at the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example patients with learning disabilities, those with long-term conditions, poor mental health and older patients were given extended appointments and children were prioritised for appointments.

The practice had access to an online interpreter service for those patients whose first language was not English to help them with their communication needs. Information in the patient waiting room was written in a number of different languages and fact sheets were available on the patient website aimed at newly-arrived individuals to the UK. The fact sheets explained the role of the National Health Service (NHS). The electronic check-in system at the practice was also accessible in a number of languages common to the local area.

The premises and services had been adapted to meet the needs of people with disabilities including a ramp at the main entrance and toilet facilities to accommodate wheelchair users. There was sufficient space in the patient waiting area to accommodate wheelchairs, mobility scooters and prams and baby changing facilities were also available.

Access to the service

The practice opening hours were 8:30–18:00 Monday to Friday and the practice was closed at weekends. Out of hours cover was provided by the NHS 111 service. Telephone consultations could be booked through reception and home visits could be arranged for those patients who were housebound. The on call GP was responsible for home visits and there were up to six available slots per day. Patients could make an appointment by telephone or by visiting the reception during opening hours. Appointments were bookable in advance with a GP of choice or same day appointments with the first available GP. Repeat prescriptions were available within 48 hours by requesting in person or online. A triage system was in place to assess the urgency of a patients needs and children were always prioritised.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The results of the national patient survey showed that 70% of respondents were satisfied with the practice's opening hours which was slightly below the local CCG average of 72%. The results of the national patient survey showed that the practice achieved above the CCG average for access in terms of the length of time patients had to wait after their appointment time to be seen, the ease of getting through on the phone and patients being able to get an appointment to see or speak to someone last time they tried. However, the results of the practice's patient survey showed that although the majority of patients could get an appointment when they needed one, patients said that it was difficult to get an appointment quickly and there was no allowance for those who worked as the practice did not offer extended opening hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that information was available in the patient waiting room and on the patient website on the complaints procedure.

We reviewed the log of complaints received in 2014. We found the practice had received two complaints in this twelve month period and they had been satisfactorily handled and dealt with in a timely way. For example, one complaint involved a patient been administered the wrong flu vaccination. The practice acted promptly and gave the patient an alternative medication. The complaint was recorded as a significant event and the appropriate staff were made aware to double check patients' computer records to see if any alerts were indicated before administering vaccinations.

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's vision was 'to deliver highest quality medical care based on evidence within the resources available to the practice'. Staff we spoke with were aware of the vision and their responsibilities in delivering it. However, the practice did not have a mission statement for patients to share in, and understand this vision.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were accessible to staff via the practices' computer system. We looked at a number of these policies and found they had been reviewed annually and were up to date. Policies we reviewed were comprehensive and included those for confidentiality, medicine management and repeat prescribing.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice had achieved 97% of QOF points available in the year 2013/14. The GPs shared responsibility for QOF and we found that QOF performance was discussed at team meetings and areas for improvement identified.

The practice participated in benchmarking and audit. The practice had benchmarked its performance against other practices in the local CCG through bimonthly network meetings. The practice was performing well in terms of referral rates for most conditions and accident & emergency attendances.

The practice participated in clinical audit and we saw evidence of completed audit cycles that showed improved outcomes for patients. These included medication audits and minor surgery.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example individual GPs took lead roles for different areas of QOF and safeguarding children and adults. A GP and a practice nurse shared the lead for infection control and the practice manager was the lead for complaints, health and safety and human resources. We spoke with four staff members who were clear on their level of responsibility and who to report to with any concerns. Staff told us they were supported in their job role.

The practice held regular meetings to discuss both clinical and non-clinical issues. For example, weekly partner meetings were held where topics such as QOF, NICE guidelines and vaccination services were discussed. There were also practice meetings held quarterly with all staff where a range of topics were discussed including IT issues, access, patient complaints and significant events.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the practices' recruitment and induction policy. Staff we spoke with knew how to access these policies and the policies had been reviewed on an annual basis. There was also a staff handbook located within the practice intranet for staff to access.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice's Patient Participation Group (PPG) met bimonthly with the practice and they had carried out annual patient satisfaction surveys to gain patients feedback on the services provided. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the patient website. These included online appointments to be made available by end of February 2015 to improve access issues, and the implementation of a texting service to remind patients of their appointments. The practice also had a quarterly newsletter encouraging patients to feedback their views and opinions of the practice and an online form on the patient website for patients to submit their comments or suggestions. There was a notice board in the patient waiting room outlining the aims of the PPG and advertisements encouraging patients to join.

The practice had gathered feedback from staff through appraisals, staff meetings and informal discussions. Staff told us they were encouraged to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they were involved and engaged in the practice to improve outcomes for both staff and patients. However, some staff we spoke to said they sometimes felt uncomfortable to raise issues.

Are services well-led?

Good

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

Management lead through learning and improvement

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients. Staff said they were supported through learning, development and appraisal.