Holly Medical Group

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?	Requires improvement
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 of Holly Medical Group on 24 February 2015.

Overall, we rated the practice as good. We found the practice to be good for providing, effective, caring, responsive and well-led services and requires improvement for providing safe services. Our key findings were as follows:

- The services had been designed to meet the needs of the local population.
- Feedback from patients was positive; they told us staff treated them with respect and kindness.
- Staff reported feeling supported and able to voice any concerns or make suggestions for improvement.
- The practice was visibly clean and tidy.
- The practice learned from incidents and took action to prevent any recurrence.

There was an area where the provider must make improvements :

- Ensure that all clinical staff that are in contact with patients have undergone checks by the Disclosure and Barring Service.

The provider should:

- Ensure that they comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 when addressing any complaints received.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Not all clinical staff that were in contact with patients had undergone checks by the Disclosure and Barring Service.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Care and treatment was being delivered in line with current published best practice. They used the data from the Quality Outcomes Framework (QOF) to assess how the practice was performing. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and implementing preventative measures. The results are published annually. The QOF data for 2013/14 showed that the practice was slightly below the national average. They had achieved an overall QOF score of 88.9% which was below the England average by 4.6%.

Patients' needs were being met and referrals to other services were made in a timely manner. The practice regularly undertook clinical audits.

Staff had received training appropriate to their roles. The practice worked with other healthcare professionals to share information.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The results of the National GP Patient Survey 2015 showed the practice was better or broadly in line with the national averages. The results also showed that patients felt the GPs and nurses involved them in decisions about their care. We saw that 97% of patients who responded said they had confidence and trust in their GP, compared to the national average 92% and 89% said their GP was good at treating them with care and concern, compared to the national

Summary of findings

average 83%. We also saw that 86% of patients said they had confidence and trust in their nurse, compared to the national average of 86% and 75% said their nurse was good at treating them with care and concern, compared to the national average 78%.

Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of their local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We saw that lessons were learnt from complaints and shared with staff.

We saw that the practice had clear and comprehensive procedures for the follow up of patients with chronic diseases. We saw evidence that the practice were appropriately reviewing the healthcare needs of people with long term conditions. For example, for patients with asthma the QOF data showed that 85.5% had an asthma review within the previous 12 months, which was 10% above the national average.

Are services well-led?

Good

The practice was rated as good for well-led. Staff told us that the practice vision was to be a successful practice that put patients first.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management team. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted upon. There was an active patient participation group (PPG). Staff had received inductions, performance reviews and attended staff meetings and events. We found there was a high level of staff engagement and staff satisfaction.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered personalised care to meet the needs of the older people in its population.

All patients over the age of 75 years had a named GP. The practice was responsive to the needs of older people, including offering home visits. They worked closely with the district nursing team based at the practice to offer coordinated care to patients.

People with long term conditions

Good

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

The practice had systems to ensure care was tailored to patients' individual needs and circumstances. We spoke with GPs and nurses who told us regular patient care reviews, for example for patients with chronic obstructive pulmonary disease (COPD - severe shortness of breath caused by chronic bronchitis, emphysema, or both) or asthmatic conditions, took place. The QOF data showed that 93.3% of these patients had a review in the preceding 12 months which was 3.7% above the national average. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and implementing preventative measures. The results are published annually. The practice ensured timely follow-up of patients with long-term conditions by adding them to the practice registers. Patients were then recalled as appropriate, in line with agreed recall intervals.

Care plans were in place for patients most at risk of deteriorating health to assist with continuity of care.

Longer appointments were offered to these patients when required.

Families, children and young people

Good

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

Systems were in place for identifying and following-up children who were considered to be at-risk of harm or neglect.

Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. Arrangements had been made for new babies to receive the immunisations they needed. The practice had a system to recall patients who had failed to attend their immunisation appointments.

There were weekly antenatal and postnatal clinics and baby clinics.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered appointments between 6.30pm and 8.00pm on Mondays. Patients could also pre-book an appointment with a GP or nurse up to eight weeks in advance.

The practice offered a range of services to their patients. In particular they attended the local universities to promote the following services to students, travel immunisations, screening for sexually transmitted infections and a full contraception service.

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.

Systems were in place to identify patients, families and children who were at risk or vulnerable. These patients were offered regular reviews. The practice worked in collaboration with other agencies, for example, health visitors and district nurses, to ensure vulnerable families and children and other patients were safe. Multidisciplinary meetings were also held regularly to monitor the care provided.

Clinical staff liaised other agencies such as housing, drug and alcohol service to provide personalised support and care for these patients.

The practice sign-posted vulnerable patients to various support groups and other relevant organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities to ensure they were safeguarded.

Summary of findings

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).

Patients experiencing poor mental health had received an annual physical health check. The practice worked closely with multidisciplinary teams in the case management of people experiencing poor mental health. For patients with dementia their care had been reviewed in a face-to-face appointment in the preceding 12 months.

The practice worked with patients experiencing poor mental health and provided personalised support. For example, with the patients consent the practice referred them to psychological services and the community mental health team when necessary.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. They told us the staff who worked there were caring and understanding, and there were no problems getting appointments. They also told us they found the premises to be clean and tidy.

We reviewed 15 CQC comment cards which had been completed by patients prior to our inspection. All were complimentary about the practice, staff who worked there and the quality of service and care provided.

The latest National GP Patient Survey published in January 2015 showed the large majority of patients were satisfied with the services the practice offered. There were 311 surveys sent out and 130 were returned.

This was a 42% completion rate. The results were:

- 98% of patients said they would recommend their GP surgery, compared to a national average of 78%;
- 89% of patients said they were 'fairly satisfied' or 'satisfied' with the opening hours, compared to the national average of 76%;
- 91% of patients said that it was 'very easy' or 'easy' to get through on the phone, compared to the national average of 72%;
- 75% of patients said that their experience of making an appointment was 'fairly good' or 'very good', compared to the national average of 74%;
- 97% of patients said their practice was 'fairly good' or 'very good', compared to the national average of 85%.

Areas for improvement

Action the service MUST take to improve

The practice must ensure that all clinical staff that are in contact with patients have undergone checks by the Disclosure and Barring Service.

Action the service SHOULD take to improve

Ensure that they comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 when addressing any complaints received.

Holly Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team also included a GP and a specialist advisor in practice management.

Background to Holly Medical Group

Holly Medical Group provides services to 8,682 patients, from 17 Osborne Road, Jesmond, Newcastle Upon Tyne, NE2 2AH. The practice area covers Jesmond, Gosforth, South Gosforth, Heaton and Sandyford. The practice provides their services under a NHS General Medical Services (GMS) contract.

The practice is located in a converted Victorian terraced house, all patient facilities are situated on the ground floor. It also offers a disabled WC, baby changing facilities, wheelchair and step-free access.

The practice has four GPs partners and two salaried GPs, three practice nurses, one health care assistant, a practice manager, an assistant practice manager and eight reception and administration support staff.

The opening times for the practice are 8.00am to 6.00pm Monday, Tuesday, Thursday and Friday. On Wednesdays it is open from 8.00am to 12.00pm and 1.15pm to 6.00pm. Extended opening hours were offered on Monday's from 6.30pm until 8.00pm.

The practice has opted out of providing urgent medical attention out of hours to their own patients and this is provided by through the NHS 111 service and Northern Doctors Urgent Care Limited.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

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 the time.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- 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. This included the local Clinical Commissioning Group (CCG).

This information did not highlight any areas of risk across the five key question areas.

We carried out an announced visit on 24 February 2015. We spoke with two patients, three GPs, one nurse, the practice manager, the assistant practice manger and four of the administration team. We also spoke with two members of the patient participation group (PPG). We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 15 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, following the loss of a prescription for controlled drugs the practice decided that this type of prescription would no longer be posted to patients and introduced a system where the prescriptions must be signed for on collection.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. We found the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Patients we spoke with said they felt safe when they came into the practice to attend their appointments. Comments from patients who completed CQC comment cards were complimentary about the service they had received and raised no concerns about their safety.

Learning and improvement from safety incidents

The practice was open and transparent when there were 'near misses' or when things went wrong. There was a system in place for reporting, recording and monitoring significant events. The practice used the Safeguarding Incident and Risk Management System (SIRMS). This is an on-line incident reporting system which enables information about incidents to be shared with CCG member practices. Staff told us that incidents were reviewed at regular practice meetings and changes were made as necessary. We saw that these were standard agenda items.

We discussed the process for dealing with safety alerts with the practice manager. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. They told us alerts came into the practice from a number of sources, including the clinical commissioning group (CCG.) All safety alerts were received by the practice manager who forwarded the email to all clinicians to action.

Reliable safety systems and processes including safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. The policy was available to all staff on the practice intranet. We saw that it was last reviewed in November 2014. The practice displayed a contact list of other agencies that may need to be informed when concerns arise such as the local police and Social Services.

The practice had a safeguarding lead for both children and adults with responsibilities for overseeing safeguarding within the practice. The safeguarding lead for children was trained to Level 3. The practice manager told us that all relevant staff had been trained and were up-to-date in safeguarding adults and children. We saw training records that confirmed this. The staff we spoke with had a good knowledge and understanding of the safeguarding procedures and what action should be taken if abuse was witnessed or suspected.

The practice manager was aware that the safeguarding lead and two nurses had not been checked by the Disclosure and Barring Service (DBS). The DBS checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice manager told us that the practice had taken steps to address this and were considering having DBS checks done for all staff. There were no minutes of those discussions. We told the practice they must ensure that all clinical staff that were in contact with patients have undergone checks by the DBS.

The practice had a process to highlight vulnerable patients on their computerised records system. This information would be flagged up on patient records when they attended any appointments so that staff were aware of any issues.

The practice had a chaperone policy which the practice manager told us they were currently reviewing. There were notices on display in the waiting area to inform patients of the availability of chaperones. Staff told us that the chaperones were trained. The staff we spoke with were clear about the requirements of their roles as chaperones. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Only clinical staff undertook chaperoning.

Requires improvement

Are services safe?

Medicines management

We checked vaccines stored in the medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. Maximum and minimum temperatures of the vaccine refrigerators were monitored daily. Vaccines were administered by nurses using patient group directions (PGDs) and patient specific directions (PSDs). PGDs and PSDs are specific guidance on the administration of medicines authorising nurses and health care assistants to administer them.

The practice used a system to remind GPs to regularly check that the medicines they carried in their GP bags were in date. GPs told us that they were responsible for those medicines. We checked one bag and found that the medicines were all in date.

We saw that the practice had a comprehensive prescribing policy. The duty GP looked at all prescribing queries. Prescription pads were securely stored in locked rooms. In addition we saw that the practice had a policy for disease-modifying-antirheumatic drugs (DMARDs). These medicines are normally prescribed as soon as rheumatoid arthritis is diagnosed. Rarely, they can have serious side-effects. DMARDS are usually taken for life. Because of this patients need to have regular blood tests, to see there are any side-effects. Staff told us that DMARD prescriptions were highlighted to remind GPs to check patient's blood results before considering reauthorising repeat prescriptions.

Staff told us that GPs had regular meetings with the practice pharmacist. The pharmacist's role included working closely with GPs to enable them to complete medication reviews. A medicines review included an examination of a patient's medicines, reaching an agreement with the patient about treatment, optimising the impact of medicines and minimising the number of medication related problems.

The practice used a system to review all hospital discharge letters and checked to ensure that any changes to medication by the hospital were appropriate and recorded on the patients' record.

Cleanliness and infection control

The practice was clean, tidy and well maintained. The patients we spoke with about the cleanliness of the practice told us that it was always clean and tidy.

The practice had a lead for infection control and an infection control policy. All of the staff we spoke with about infection control said they knew how to access the practice's procedures for infection control and had received infection control training. We saw the last infection control audit took place in February 2014 which did not highlight any concerns.

The risk of the spread of infection was reduced as all instruments used to examine or treat patients were single-use, and personal protective equipment (PPE), such as aprons and gloves, were available for staff to use. Hand washing instructions were also displayed by hand basins and there was a supply of liquid soap and paper hand towels. We saw training records that showed most clinical staff had received infection control training in the last 12 months. The practice had undertaken a hand hygiene audit in 2014 which was repeated in January 2015 which showed that there had been improvements.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. The practice had a system for handling patient specimens. Staff talked us through the safe process from receipt to disposal.

We saw that a legionella risk assessment took place in October 2013 no concerns were identified. Legionella is a bacterium that can grow in contaminated water and can be fatal.

Equipment

The practice had processes in place to make sure that equipment was regularly checked to ensure that it was safe and effective to meet patients' needs. The fire extinguishers were checked in August 2014. We saw that all the medical equipment had been check or calibrated in January 2015. We saw that the defibrillator was checked daily. We saw that a portable appliance test (PAT) was due to be completed again August 2015. (Portable appliance testing (PAT) is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.)

Staffing and recruitment

We saw that the practice had a recruitment policy. However, we saw evidence that this had not always been followed. The practice manager explained that there had been some fundamental changes to the partnership and management structures recently. As such the practice

needed to recruit a practice manager at short notice. The practice manager was initially offered a temporary position and this was later changed to a permanent position. The practice was aware that they had not followed their own recruitment policy in this instance. The practice manager told us that they were looking to introduce a recruitment policy to cover similar circumstance in the future.

The practice manager told us they took up references. Staff we spoke with confirmed this. They also obtained photographic proof of identity and satisfactory documentary evidence of any relevant qualifications in accordance with regulations. The practice provided an induction process for all new staff. A new member of staff we spoke with confirmed that they had completed a period of induction.

We saw that the practice had a system to regularly check that the GPs and nurses had maintained their registration which allowed them to practice. For example, we saw that the GPs were registered and three of them were due to undertake the GP revalidation process shortly. Revalidation is the process by which doctors demonstrate they are up to date and fit to practise.

The practice manager told us that they employed sufficient numbers of suitably qualified, skilled and experienced staff. The practice had a procedure for managing staff absences.

Appropriate staffing levels and skill-mix were provided by the practice during the hours the service was open. Staff we spoke with were flexible in the tasks they carried out and they also told us that they worked well as a team and covered for each other when necessary to ensure their patients received good care.

Monitoring safety and responding to risk

The practice had a health and safety policy. Staff were reminded, by a health and safety poster of their individual responsibility for the health and safety of themselves and other people who may be affected by the practice's activities.

Staff told us that the fire alarms were tested weekly. The new practice manager was unable to say when the staff had undertaken a fire training course. However, they provided us with evidence which showed that they had booked a course for March 2015.

Arrangements to deal with emergencies and major incidents

The practice had detailed plans in place to ensure business continuity in the event of any foreseeable emergency, for example, a fire or flood. The practice manager told us that they had an arrangement to see their patients at a nearby practice if they if they were unable to gain entry to the practice.

The practice had resuscitation equipment and medicines available for emergencies. Arrangements were in place to check emergency medicines were within their expiry date and suitable for use. All of the staff we spoke with told us they had either attended CPR (resuscitation) training or refresher training had been scheduled. We looked at records which confirmed this. This ensured staff had sufficient support and knew what to do in emergency situations.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was considered in line with recognised best practice standards and guidelines.

GPs and nurses demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was an emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and from local health commissioners NHS Newcastle North and East Clinical Commissioning Group (CCG).

We saw that the practice used the Information from the Quality and Outcomes Framework (QOF) to monitor their patients. For 2014 the practice was broadly in line with the national average. The practice achieved an overall score of 88.9% which was below the England average by 4.6%. (The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions, e.g. diabetes and implementing preventative measures. The results are published annually).

The practiced had processes in place to ensure current guidance was being followed. They used the data from the Quality Outcomes Framework (QOF) to assess how they were performing following the current guidance. The practice was aware of their achievements in comparison to other local practices and nationally. For example, for patients with chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis and emphysema) the QOF data showed that 93.3% had a review, including an assessment of breathlessness, in the preceding 12 months, which was 1.3% above the local CCG average and 3.7% above the national average.

The practice coded patient records using specific READ Codes. These are codes which provide the standard vocabulary by which clinicians can record patient findings and procedures in health and social care IT systems. This enabled them to easily identify patients with long-term conditions and those with complex needs. We found from our discussions with the GPs and the nurses that staff completed, in accordance with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, the practice had planned for, and made arrangements to deliver, care and treatment to meet the needs of patients with long-term conditions. There were regular clinics where patients were booked in for an initial review of their condition; they were then scheduled for recall appointments. This ensured patients had routine tests, such as blood or spirometry tests to monitor their condition (A spirometer measures the volume and speed of air that can be exhaled and is a method of assessing lung function).

We saw that the practice had clear and comprehensive procedures for the follow up of patients with chronic diseases. We saw evidence that the practice were appropriately reviewing the healthcare needs of people with long term conditions. For example, for patients with asthma the QOF data showed that 85.5% had an asthma review within the previous 12 months, which was 10% above the national average.

All patients over the age of 75 had a named GP who was responsible for their care. Patients could request a different GP if that was their preference. This helped to ensure continuity of care.

The practice kept a register of patients with learning disabilities which enabled them to monitor their care effectively

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles, which led to improvements in clinical care. We saw an example of an audit of patients diagnosed with chronic kidney disease (CKD). The initial audit highlighted that 54% of the patient's had not received a second blood test to confirm the diagnosis or their records were not coded for CKD. Action was taken by the practice to address this and a second audit showed that the figure had reduced to 28%. The practice was aiming to ensure that all patient records for patients diagnosed with CKD are coded and a further audit has been scheduled for July 2015 to check progress.

We saw that the practice used data from the quality, innovation productivity and prevention (QIPP) system to monitor their achievements. Their antibiotic prescribing

Good

Are services effective?

(for example, treatment is effective)

rates were better than the CCG target and had improved. For example in comparison with the other 17 practices in the CCG area they were sixth in 2013/14 at quarter 4 and fifth in 2014/15 at quarter 1.

We reviewed a range of data available to us prior to the inspection relating to health outcomes for patients. We saw that under the clinical heading the overall achievement for QOF 2013/14 was 88.9%, which was 4.6 percentage points below the England average.

The practice used the information from QOF to monitor the practice's progress against their QOF targets to ensure that patients were invited for routine regular monitoring tests such as blood pressure checks.

The practice had systems to ensure care was tailored to patients' individual needs and circumstances. The practice held registers of various patients, such as those with learning difficulties aged 18 and over, patients suffering from Chronic Obstructive Pulmonary Disease (COPD) – severe shortness of breath caused by chronic bronchitis, emphysema or both. These enabled the practice to monitor those patients and the care offered. We saw evidence that patients with complex needs had their care planned. The QOF data showed that 94.1% of patients on their diabetes register had eye tests in the preceding 12 months, which was 4.4% above the local CCG average and 4.1% above the national average. In addition 91.8% of patients with mental health issues had a comprehensive care plan documented in the record, in the preceding 12 months; this was 5.9% higher than the national average.

Effective staffing

Practice staffing included administrative, clinical and managerial staff. We reviewed staff training records and saw that the practice had a method of recording training undertaken and when the training needed updating. Clinical staff maintained their individual continuing professional development (CPD) records. Good medical practice requires doctors and nurses to keep their knowledge and skills up to date throughout their working life and to maintain and improve their performance. CPD is a key way for them to meet their professional standards.

We saw from the staff training records that staff had attended courses which included safeguarding for children and vulnerable adults, and fire safety. All staff were up-to-date with mandatory courses such as basic life support. Staff undertook 'Time in and Time out' training courses which gave them an opportunity to undertake undisturbed formal and informal training.

All GPs 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 NHS England can the GP continue to practice and remain on the performers list with NHS England).

Staff had received annual appraisals. The practice manager told us that the nurses' appraisals were overdue but they were scheduled to take place shortly. During the appraisals, training needs were identified and personal development plans put into place. The practice had an 'open door' policy whereby all staff were encouraged to freely raise any issues or concerns in meetings or privately with the practice manager, and GPs. All staff we spoke with confirmed this and told us they would have no problems in raising any issues and also said they felt well supported by the practice.

Staff told us that they worked well as a team and were mutually supportive. The practice manager told us that the nurses undertook clinical supervisions of each other and the GPs undertook their clinical supervisions of each other.

We looked at the training records for the practice and saw that they offered staff training that covered safeguarding, information governance and Cardiopulmonary resuscitation (CPR), among other courses appropriate to their work.

The patients we spoke with were complimentary about the staff. There were no negative comments, and 13 positive comments, about staff in the 15 CQC comment cards we reviewed.

Working with colleagues and other services

The practice worked closely with other health and social care providers to co-ordinate care and meet their patients' needs. For example, they worked closely with the district nursing team based at the practice to offer coordinated care to patients. The practice also worked closely with a nursing home and in collaboration with the home they introduced a new regime for visiting their patients which included ward rounds.

Good

Are services effective?

(for example, treatment is effective)

Multidisciplinary meetings which included practice nurses, GPs, district nurses, health visitors and other health care professionals were held regularly. The practice gave us an example of a time they had worked with other services for the benefit of their patients. They held a multidisciplinary meeting with the community mental health team and agreed a management plan to prevent extra prescribing of medication to a patient with a history of poor mental health and medicines abuse.

Correspondence from external health care and service providers, such as letters from hospital including discharge summaries, blood tests, information from out-of-hours providers and the 111 service, were received both electronically and by post and distributed to relevant staff to action. For example blood test results were sent to the requesting GP and the duty GP to review.

Information sharing

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. These records generated alerts which included prompts to staff that a patient needed medical reviews such as blood tests.

Staff told us that they shared patient information with the out of hour's service which helped ensure that their patients received appropriate care.

Regular meetings were held throughout the practice. These included staff, clinical and multidisciplinary team meetings. Information about risks and significant events were shared openly at meetings. Patient specific issues were also discussed with appropriate staff and other health care professionals to enable continuity of care. We were given examples of clinical issues that were discussed at multidisciplinary meetings. We saw notes of a practice meeting held in December 2014, topics discussed included training, unplanned admissions and complaints.

Consent to care and treatment

Staff we spoke with were able to give examples of how they obtained implied, verbal and written consent.

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their responsibility in respect of consent prior to giving care and treatment. They described the procedures they would follow where patients lacked capacity to make an informed decision about their treatment. The practice told us about an anonymized case study where the practice worked with the community psychiatric nurse in deciding the patient lacked capacity and made a best interest decision to admit the patient into hospital. .

The clinicians we spoke with showed they were knowledgeable about how and when to carry out Gillick competency assessments of children and young people. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Health promotion and prevention

A range of health promotion information was available to patients in the reception and waiting area of the practices. This included information about lifestyle management such as smoking cessation.

The practice proactively identified patients who needed ongoing support. In particular, they identified carers and placed a flag on their records so that clinicians were made aware of this before these patients attended appointments. The practice undertook annual reviews for patients with long term conditions or more frequently when needed.

The practice identified patients who would benefit from treatment and regular monitoring, for example, they offered flu vaccinations and immunisations for children in line with current national guidance. Data showed that 92.2% of children received the second dose of the MMR vaccination, compared to the CCG average of 92.7%.

The practice told us that they were proactive and opportunistic when offering NHS health checks to patients. The practice offered various health checks which included health checks for patients between 40 to 70 years old.

The practice nurses held travel clinics and offered travel vaccinations if required

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with two patients during our inspection. They were complimentary about the services they received. Comments left by patients on the 15 CQC comment cards we received also reflected this.

We looked at data from the National GP Patient Survey, published in January 2015. They issued 311 questionnaires and 130 were returned. The results showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 97% of patients who responded to the survey said they thought their overall experience was good, compared to the national average 85%. For the helpfulness of reception staff the practice achieved 93%, compared to the national average 87%. We saw that 97% of patients said they had confidence and trust in their GP, compared to the national average 92% and 89% said their GP was good at treating them with care and concern, compared to the national average 83%. We also saw that 86% of patients said they had confidence and trust in their nurse, compared to the national average of 86% and 75% said their nurse was good at treating them with care and concern, compared to the national average 78%.

Staff we spoke with told us how they would protect patient's dignity. Consultations took place in purposely designed consultation rooms with an appropriate couch for examinations and curtains to maintain privacy and dignity. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in those rooms could not be overheard.

We saw the reception staff dealt with patients pleasantly and warmly. They were aware of the need for confidentiality. They ensured conversations were conducted in a confidential manner. For example, a radio was playing in the background to obscure their conversation and staff also spoke quietly so their conversations could not be overhead. Patients could speak to the receptionist through a purpose built hatch, which was adjacent to the main combined reception and waiting room, which provided some further privacy. In addition the practice displayed a notice offering patients the opportunity to speak to staff in a private room if they wished.

Care planning and involvement in decisions about care and treatment

Patients told us they felt they had been involved in decisions about their care and treatment. They told us that the clinical staff took their time with them and always involved them in decisions. The results of the National GP Patient Survey from January 2015 showed patients felt the GPs and nurses involved them in decisions about their care. Of those who responded, 91% of patients surveyed rated GPs good at involving them in decisions, compared to the national average 75%. For nurses this was 65% compared to the national average 66%. In addition 88% of patients surveyed rated GPs good at explaining the need for any test or treatments, compared to the national average 82%. For nurses this was 76% compared to the national average 77%. This demonstrated that most patients who responded were satisfied with the way they were treated.

We saw that access to interpreting services was available to patients, should they require it.

Patient/carer support to cope emotionally with care and treatment

Staff told us that in addition to pre-bookable appointments the practice offered urgent appointments on the same day. These services gave patients assurance that their needs would be met on the day they contacted the practice. The practice also undertook home visits for those patients not well enough to attend the practice.

The practice offered support to patients receiving end of life care at home. Such as having a care plan which included a record of patient's wishes in the event of cardiac or respiratory arrest. Staff told us that bereaved relatives and carers would be contacted by the practice to offer them support.

We saw there was a variety of patient information on display throughout the practice. This included information on health conditions, health promotion and various support groups and services.

The practice worked with patients experiencing poor mental health and provided personalised support. For example, staff told us they referred patients to counsellors, mental health workers and the community psychiatric nurse if necessary. The practice also signposted patients to talking therapies for support.

Good

Are services caring?

The practice held regular multidisciplinary team meetings where they planned care for patients, such as those experiencing mental health problems, who would benefit from coordinated support from other health care providers in conjunction with the care provided by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff told us that patients suffering from some long term conditions such as diabetes were given longer appointment times with the practice nurses if necessary. Patients with learning difficulties were given longer review appointments with GPs.

Patients we spoke with told us they felt they had sufficient time during their appointment. Results of the National GP Patient Survey from January 2015 confirmed this with 89% of patients stating the doctor gave them enough time and 79% stating they had sufficient time with the nurse. These results were above and in line with the national averages (85% and 80% respectively).

The practice used electronic notes and alerts which were attached to medical records to advise staff that patients had additional needs such as, for example, a learning disability, on the palliative care register or that they were a carer.

The practice offered personalised care to meet the needs of the older patients in its population. Patients over the age of 75 years had a named GP. Patients could request to be seen by their usual GP. There was information available to patients in the waiting room and reception area about support groups, various clinics such as the flu clinics, and health and wellbeing advice.

Tackling inequity and promoting equality

The practice had recognised the needs of the different groups in the planning of its services.

Nationally reported data showed the practice had achieved good outcomes in relation to meeting the needs of patients whose circumstances may make them vulnerable. Registers were maintained, which identified which patients fell into these groups. The practice used this information to ensure patients received an annual healthcare review and access to other relevant checks and tests. Patients experiencing poor mental health had their needs reviewed. For example, 91.8% of patients with mental health issues had a comprehensive care plan in their records in the preceding 12 months. This was 5.9% higher than the national average.

Staff told us that the practice offered extended appointments for patients who needed them.

The practice buildings had step free access for patients with mobility difficulties. The consulting and treatment rooms were accessible for all patients. There were disabled toilet and baby changing facilities available at the practice.

The practice had arrangements in place to access interpretation services for patients whose first language was not English.

Access to the service

The opening times for the practice were 8.00am to 6.00pm Monday, Tuesday, Thursday and Friday. On Wednesdays it was open from 8.00am to 12.00pm and 1.15pm to 6.00pm. Extended opening hours were offered on Monday's from 6.30pm until 8.00pm.

Routine appointments could be pre-booked up to eight weeks in advance. GPs had on the day appointments available in the morning and afternoon. Feedback from patients we spoke with, and those who completed CQC comment cards, did not raise any concerns about getting an appointment with a clinician on the day if their need was urgent.

The most recent National GP Patient Survey (2015) showed 75% of respondents described their experience of making an appointment as 'very good' or 'fairly good', in comparison to the national average 74% and 98% said that the last appointment they got was 'convenient for them', in comparison to the national average 92%.

Patients were able to book appointments either by calling into the practice, on the telephone, using a mobile phone app or online. Home visits were available for patients who needed them. The practice also offered patient reviews over the telephone.

The practice had an up-to-date practice leaflet which provided information about the services available, contact details and repeat prescriptions. The practice also had a clear, easy to navigate website which contained detailed information to support patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. However, the practice did not always follow their policy. We saw the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice had received an anonymous complaint which it had not recorded or investigated appropriately. We discussed this with the practice manager and a GP partner. They told us that the complaint was received at a time of change at the practice and thought it was vexatious rather than a genuine complaint. However, they accepted they had not followed their complaints policy in this instance.

We saw a summary of the complaints the practice had received between May 2014 and January 2015. There were 15 entries. The summary included brief details of the complaint, the actions taken to address the complaint and any learning points to be shared and the outcome. All but one complaint had been resolved. The unresolved complaint was being followed up by NHS England as it also involved secondary care and support staff.

There was information displayed in the waiting room and within the practice leaflet, informing patients of the practice complaints process.

None of the four patients we spoke with on the day of the inspection said they had felt the need to complain or raise concerns with the practice. In addition, none of the 15 CQC comment cards completed by patients indicated they had felt the need to make a complaint.

Staff we spoke with were aware of the complaints policy and the action they needed to take if they received a complaint which included informing the practice manager of any complaints made to them.

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

Staff we spoke with told us that the practice vision was to be a successful practice that put patients first.

The staff we spoke with all knew and understood the vision and values and what their responsibilities were in relation to these. Staff told us that they felt well supported in their roles.

The practice manager told us that the practice had an open culture where staff were encouraged to discuss issues with colleagues and GPs when the need arose. Staff we spoke with confirmed this and told us that the practice was very supportive and they had no concerns about raising any matters with colleagues, GPs or the practice manager.

Governance arrangements

We saw that the practice had developed a clear leadership structure showing lines of accountability for all aspects of patient care and treatment. This included details of nominated individuals who were responsible for various clinical and non-clinical areas. For example, staff undertook lead roles in such areas as infection control and monitoring QOF data and practice performance.

The practice had a number of policies and procedures in place which governed their day-to-day activities. Staff were able to access these electronically. Staff worked in accordance with their policies and procedures, for example, they told us they followed patient group directions (PGDs) and patient specific directions (PSDs). These are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. The policies and procedures that were in place, and feedback from staff, showed us that effective governance structures were in place.

Staff told us that they interacted with their colleagues throughout the day, supporting each other to provide their services to patients. We saw that the practice held various regular team meetings such as weekly clinical and partners meetings and monthly multidisciplinary meetings.

Leadership, openness and transparency

The practice had a clear corporate structure designed to support transparency and openness. There was a well-established management team with clear allocation of responsibilities. Management had a good understanding of, and were sensitive to, the issues which affected patients and staff.

Staff told us they worked in a supportive team and there was an open culture in the practice and felt they could report any incidents or concerns they might have. This environment helped to promote honesty and transparency at all levels within the practice.

Staff told us that following recent changes at the practice there was now a more open culture generally and in particularly more transparency around business and financial planning. The practice manager told us that they spoke with staff on a daily basis and operated an 'open door policy' so that staff could speak to them at any time. The practice also recently introduced a monthly newsletter for communication with staff.

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

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions in their day-to-day activities. Staff we spoke with told us these meetings provided them with the opportunity to discuss the service being delivered, feedback from patients and raise any concerns they had. They said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff also told us that the practice was open to suggestions and acted upon them. We saw the practice also used the various meetings to share information about clinical and administration issues.

We saw that the practice had conducted a patient survey in 2013/14 and received 207 responses. The responses were analysed and in collaboration with their patient participation group (PPG) an action plan was formulated. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Action was taken by the practice to address the issues highlighted. For example, the survey showed that 84.6% of the patients felt the premises were adequate. However, the practice were concerned that the patients were not fully aware of the constraints staff were working under in the converted Victorian terraced house. As such the practice was looking to relocate locally.

Are services well-led?

Good

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

We spoke with two members of the PPG. They said the PPG had been in existence since 2011. PPG meetings were held approximately every two months. They said they had been involved in drafting of the practice PPG leaflet. The members told us that their relationship with the practice was positive and constructive; they felt listened to and their opinions were valued, which encouraged open debate.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance.

Staff told us that the practice was supportive of training. They said they had received the training they needed or it had been scheduled, both to carry out their roles and responsibilities and to maintain their clinical and professional development. The practice undertook regular training workshops within the practice. Staff also attended 'Time Out' workshops run by the CCG. The workshops they offered included training in areas such as palliative care guidelines, Mental Capacity Act and antibiotic prescribing. Staff told us that they had appraisals which included agreeing future training courses to enhance their skills.

The practice provided training placements to medical students as part of their training to become doctors. They also provided training places for qualified doctors in the second year of their foundation (post qualification) training programme. This demonstrated that the practice staff shared their skills and experience with colleagues for the benefit of patients.

The practice had an effective approach to incident reporting in that it encouraged reporting and the review of all incidents. Team meetings were held to discuss any significant incidents that had occurred. The practice had completed reviews of significant events and other incidents and shared these with staff and other relevant health care providers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not ensured that all clinical staff that are in contact with patients have undergone checks by the Disclosure and Barring Service. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.