# Innovision Healthcare Ltd

## Quality Report

Willesden Centre for Health, Robson Avenue,
London, NW10 3RY
Tel: 020 8438 7330
Website: www.burnleypractice.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 Innovision Healthcare Limited on 21 October 2014. We rated the practice as 'Good' for the service being 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 practice had a good track record on safety and safety incidents were dealt with promptly.
- The practice was clean and hygienic and infection control standards were maintained by staff.
- Staff had received adequate training to deliver effective care and treatment to patients.
- Feedback from patients was overall positive. They said staff were caring, professional and respectful.
- A range of appointments were available for patients to access services including a Hub service to fit around patients' needs.
- The practice sought feedback from patients and staff and made improvements to the service where necessary.

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

The provider should:

Complete clinical audit cycles to ensure that identified improvements are achieved and maintained

**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. Systems were in place to monitor safety and ways to improve identified. Safety incidents were investigated and learning shared with all staff. Safeguarding procedures were in place to protect children and adults from harm and staff knew their responsibilities in relation to reporting safeguarding concerns. An infection control policy was in place and cleaning standards were monitored. Medicines were managed safely and staff were trained to deal with emergency situations. The necessary pre-employment checks had been completed on staff and there were enough staff to keep people safe.

**Are services effective?**

Good

The practice is rated as good for providing effective services. Processes were in place to ensure that all clinical staff had access to updates in guidelines from the National Institute for Health and Care Excellence (NICE) and local commissioners. The practice used their Quality and Outcomes Framework (QOF) performance to improve clinical outcomes for patients. The practice undertook regular review of patients medications to ensure they continued to receive appropriate treatment. We found that clinical audit was carried out but the practice was unable to show us evidence of completed audit cycles to ensure improved outcomes for patients. The practice worked with other health care professionals to plan effective care for patients with more complex needs. The staff team had a good mix of skills and received training to deliver effective care.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was positive. Patients said they were treated with dignity and respect and this was reflected in the results of the 2014 national GP patient survey. Patients said that clinical staff involved them in decisions about their care and treatment and they felt supported and listened to by staff. Patients were satisfied with the emotional support provided by staff and the practice signposted patients to bereavement support services.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. The needs of the local population were understood and services were in place to meet them including improved access for patients to fit around their work commitments and outreach clinics for homeless patients. The practice had implemented suggestions for

# Summary of findings

improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The practice had a range of appointments available and extended opening hours. The practice also ran a Hub service, providing extra appointments during the week and on Saturday mornings. The practice had a system in place for handling complaints and concerns and all complaints received had been resolved appropriately.

**Are services well-led?**

Good

The practice is rated as good for being well-led. The practice had a clear vision to expand its services by focusing on the quality of care, access to services and the continuity of the clinical team. Policies and procedures were in place to govern activity and these were available to staff working at the practice. There was a clear leadership structure which had named members of staff in lead roles. Staff understood their own roles and responsibilities and they felt valued, supported and knew who to go to in the practice with any concerns. The practice gathered feedback from patients and staff, and acted on it.

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## 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. The practice offered proactive, personalised care to meet the needs of the older people in its patient population. For example, the practice had developed care plans for older patients to avoid unnecessary admissions to secondary care and a named GP for all patients over 75 years old. The practice held monthly multidisciplinary team meetings with other health care professionals to plan effective care for patients known to be nearing the end of life. The practice was responsive to the needs of older people, including offering home visits and extended appointments. The practice was caring and offered emotional support to older patients who were bereaved.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. GPs had lead roles in the management of patients with long-term conditions and the practice nurse supported this work which allowed the practice to focus on specific conditions such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and asthma. All these patients had annual reviews to check their health and medication needs were being met. For patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice monitored its management of long-term conditions through the Quality and Outcomes Framework (QOF). The practice had achieved the QOF targets in relation to maintaining various disease registers for its practice population over the previous two years.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. The practice held a range of clinics to meet the needs of this population group. For example, family planning, antenatal/ postnatal, contraceptive and well child clinics. The practice held multidisciplinary team meetings monthly to review the needs of complex patients including children on the “at risk” register. The practice had an alert system in place to highlight children on child protection plans and GPs attended child protection meetings to discuss at risk children and plan care for them. Staff were trained to recognise the signs of abuse in children and they knew the reporting procedures if they had any concerns. Appointments were available outside of school hours and the premises was suitable for children and babies.

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**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified and the practice had adjusted the availability of the services it offered to ensure these were accessible. For example, the practice offered extended opening hours on Wednesday evenings and Saturday mornings to fit around patients work commitments. For patients unable to get an appointment due to work commitments the practice provided a Hub service. (A pilot project developed by NHS England, designed to support GPs to deal with a high demand for appointments). The Hub provided an extra 30 appointments daily from 3.00-9.00pm and Saturdays 9.00-3.00pm. The practice offered a full range of health promotion and screening.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and 60% of these patients had care plans in place. The practice provided outreach clinics and clinics at the practice for homeless patients to ensure they accessed primary care services. The lead GP had completed methadone training and attended a drug and alcohol course to gain additional knowledge to provide extra care for patients with drug and alcohol problems. Patients were also signposted to local drug and alcohol services for support when necessary.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice was proactive in treating patients experiencing poor mental health. For example, the practice held a register of patients with dementia and had developed care plans for these patients. Patients with dementia were reviewed annually and their care plans updated to reflect any changes in their health. The practice proactively offered support and treatment for patients experiencing poor mental health. Data showed the practice scored above the national average in the previous year for the percentage of patients with mental health conditions whose notes contained an offer of support and treatment within the preceding 15 months.

# Summary of findings

## What people who use the service say

We spoke with six patients during the course of our inspection including the chair of the Patient Participation Group (PPG). We reviewed 22 completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service, information published on the NHS Choices website, the results of the practices most recent patient experience survey and the national patient survey.

All the patients we spoke with and the CQC comment cards received were positive about the practice and staff. Patients said all the staff were friendly and treated them in a respectful manner. The results of the national patient survey showed that 84% of patients described their overall experience of the practice 'as good.' Patients were satisfied with the practice's opening hours and the standard of care they received.

## Areas for improvement

**Action the service SHOULD take to improve**

Complete clinical audit cycles to ensure that identified improvements are achieved and maintained.

# Innovision Healthcare Ltd

**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 Innovision Healthcare Ltd

Innovision Healthcare Limited (aka The Burnley Medical Practice) is situated in Willesden Centre for Health, 1st Floor, Robson Avenue, London, NW10 3RY. The practice provides NHS primary medical services through an Alternative Provider Medical Service (APMS) contract to 4500 patents in the local community. The practice is part of NHS Brent Clinical Commissioning Group (CCG) which is made up of 67 GP practices. The practice serves a young population group with patients predominantly in the 25-45 years age range with diverse ethnic backgrounds. The practice staff comprise of two salaried male GP's, one salaried female GP, a nurse practitioner, a practice nurse, healthcare assistant, practice manager and a small team of reception/administration staff. The practice is supported by the providers corporate team.

The practice opening hours are Monday to Friday 8.00am to 6.30pm with extended hours on Monday until 8.00pm. The practice is also open Saturday mornings from 9.00am to 12.00pm.

The practice currently runs a Hub service piloted by NHS England which supports GP's in the local area to deal with a high demand for appointments with sessions running from 3.00pm to 9.00pm weekdays and 9.00am to 3.00pm Saturdays. The practice has opted out of providing out-of-hours services to its patients and refers patients to the 111 out-of-hours service.

The practice provides a range of clinics including clinics for child and travel vaccinations, smoking cessation, family planning, antenatal and postnatal and outreach clinics for homeless patients. The practice has their own phlebotomy service. The practice also works closely with charity partners and local hostels to ensure the hostel and homeless community access GP services.

## 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.

## 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?

# Detailed findings

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 October 2014. During our visit we spoke with a range of staff including a member of the corporate team, two GP's, a practice nurse, the practice manager and two reception/administration staff. We spoke with five patients who used the service and the chair of the patient participation group (PPG). We reviewed 22 completed Care Quality Commission (CQC) 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 patient safety. For example, reported incidents and 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.

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

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last two years and these were made available to us. Significant events were discussed at practice meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, one incident we reviewed involved a hospital letter assigned to the wrong patient record. The incident had been recorded and prompt action taken to rectify the error. The incident had been discussed with relevant staff to ensure it did not happen again. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

National patient safety alerts were disseminated via email by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. For example a safety alert was received regarding a discontinued medicine. This was disseminated to relevant staff. Patients who had been prescribed the medicine were reviewed and their medicine changed as a result. Staff also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where action needed to be taken.

### 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. All clinical staff were trained to Level 3 in child protection and non-clinical staff to Level 1. We asked members of medical, nursing and administrative staff about their most recent 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 who had been trained to Level 3 to enable them to fulfil this role. 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 however the policy was not displayed for patients to view. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone the receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. All non-clinical staff carrying out chaperoning duties had an up to date criminal check via the Disclosure and Barring Service (DBS).

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system (EMIS) which collated all communications about the patient including scanned copies of communications from hospitals.

### 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.

Good

# Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with relevant regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an independent prescriber and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, the training requirements of staff generating repeat prescriptions and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

## Cleanliness and infection control

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the lead had carried out annual infection control audits and that any improvements identified for action were completed on time. For example the most recent audit had identified there was no procedure displayed instructing staff on managing body substance spillages. As a result procedures for managing spillages had been displayed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury and the policy was displayed for staff to reference.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a risk assessment for the management, testing and investigation of Legionella (a bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks as recommended in their risk assessment in order to reduce the risk of infection to staff and patients.

## 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the fridge thermometer, spirometers, blood pressure monitors and the defibrillator.

## Staffing and recruitment

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

Good

# Are services safe?

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.

The practice had Service Level Agreements in place with locum agencies however, the use of locum GPs was rarely needed.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building and the environment. The practice had a health and safety policy and an identified health and safety representative who staff were aware of if they needed to report any concerns.

Health and safety risk assessments were in place including risk assessments for fire, legionella bacteria and infection control. Where risks had been identified control measures were in place to minimise them. Health and safety was discussed at staff meetings where the findings of risk assessments were shared with staff.

### 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. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked daily.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included emergency medicines for the treatment of anaphylaxis and myocardial infarction. 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 may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the relevant electricity company to contact in the event of electrical failure.

A fire risk assessment had been undertaken that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE guidelines were accessible through the computer system for clinical staff to view. Updates were also distributed to GPs in the practice by the lead GP. The lead GP told us that NICE guidelines were not routinely discussed in staff meetings however, it was something they were planning to do in the future. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. GPs completed British Medical Journal online courses and attended 'hot topic' courses to keep their knowledge up to date and relevant. GPs also kept up to date by attending weekly education sessions provided by the Innovision corporate team.

Individual GPs took the lead for specialist clinical areas such as diabetes, heart disease, chronic obstructive pulmonary disease (COPD) and asthma. The practice nurse supported this work which allowed the practice to focus on patients with these specific conditions and deliver effective care to them. Annual reviews were carried out on all patients with long-term conditions in line with best practice guidance.

The practice referred patients to secondary care and other community care services in line with national guidance. This included urgent two week wait referrals for suspected cancer.

Data showed that the practice was above the CCG average for referral rates to secondary care. The practice had carried out an audit and found that up to 50% of referrals were re-referrals due to patients not attending or the hospital failing to send out an appointment. As a result the practice had put a system in place whereby patients were told to contact the practice if they had not been seen within the agreed timeframe, and in which case staff would contact the hospital to follow up.

The practice was above the CCG average for cancer diagnosis by accident and emergency admissions. The practice had reviewed admissions and found that 50% of patients attending A&E were vulnerable patients who had not contacted the practice before attending hospital. The practice was working to reduce A&E admissions by providing outreach clinics for these vulnerable patients.

The practice provided effective care to patients with complex needs. Patients identified as having complex needs by the computerised risk tools were invited in for a consultation. The GPs developed care plans for these patients when they attended the practice. Care for patients with complex needs was discussed at monthly multidisciplinary team meetings and the meeting minutes we reviewed confirmed this.

The practice provided a new enhanced service (services which require an enhanced level of service provision above what is normally required under the core GP contract) to reduce unnecessary admissions to secondary care of at risk patients. The practice was required to develop care plans for two percent of the practice population over 18 years. At the time of our inspection the practice had 70 care plans in place and had reached target. The practice also had developed 25 multidisciplinary care plans for patients with specific long-term conditions such as diabetes and heart disease.

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 its target in their Quality and Outcomes Framework (QOF) performance over the last two years. 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. QOF performance was continuously monitored and areas for improvement identified. Clinical conditions where the practice had improved their performance included dementia and heart disease.

We saw a selection of medicine reviews completed in line with CCG requirements. For example, reviews of patients taking multiple medicines. Patients identified had been

Good

# Are services effective?

(for example, treatment is effective)

contacted and reviewed to reduce the number of medicines they were being prescribed. However, we found clinical audit was limited and there was no evidence of a systematic approach to improving outcomes for patients.

The practice participated in benchmarking and peer review with other practices in the CCG. We found the practice had participated in peer review on three occasions over the last 12 months. Topics discussed included referrals to secondary care, accident and emergency attendances, prescribing and unplanned admissions to hospital.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, child protection, confidentiality, record management, fire training and health and safety. The GPs had a range of experience and skills relevant to the needs of the practice population. For example, the lead GP had a special interest in drug and alcohol issues and had attended a drug and alcohol course to provide focused care for patients with these problems. The GPs were registered with the General Medical Council (GMC) and the nurses registered with the Nursing and Midwifery Council (NMC).

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. All staff including locums had completed an induction programme when they started working for the practice.

All staff received an annual appraisal and developed a personal development plan. Staff told us they were actively encouraged to develop and contribute to their personal development plan.

### 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 and dealt with in a timely manner.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses and were used to review and plan the care for these patients. GPs also attended child protection/vulnerable adults meetings to discuss at risk patients.

The lead GP attended weekly sessions at the local homeless centre and worked with the social services, mental health workers and probationary services to identify vulnerable patients in need of care and treatment. These patients were invited by the practice for consultations and health screening. The practice worked closely with homeless services by providing weekly outreach clinical sessions as well as clinics for homeless patients run at the practice.

The practice worked with the referral facilitation service. The service reviewed all referrals made by the practice to secondary care and any not fulfilling the required criteria were sent back to the practice for review. This ensured all referrals were made appropriately.

### Information sharing

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

The practice had an electronic system for informing other agencies such as Coordinate My Care about patients in vulnerable circumstances. For example, those patients whose health was at risk of deteriorating during the night. This information was then available to other health agencies such as the ambulance service if needed.

### 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 under this legislation. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice, for example, when recording requests around do not attempt cardiopulmonary resuscitation (DNACPR). A GP showed us an example of a recent DNACPR decision that had been made for an end of life care patient and best interest decisions made in line with the Mental Capacity Act 2005.

Good

# Are services effective?

## (for example, treatment is effective)

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us 60% of patients with learning disabilities had a care plan in place.

GPs we spoke with had a clear understanding of Gillick competencies to obtain consent from children, (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

### Health promotion and prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

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. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice offered NHS Health Checks to all its patients aged 40-75. Practice data showed that 45% of patients in this age group took up the offer of the health check in the previous year.

The practice had a number of 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. The practice had 10 patients with learning disabilities and they had been offered annual physical health checks. Practice records showed four had received an annual health check and six had a care plan in place. The practice had also identified the smoking status of its patient population over the age of 16 and actively offered smoking cessation advice to these patients. Latest figures showed that smoking cessation advice had been given to 97% of chronic disease patients and 90% of all patients who were smokers. At the time of our inspection the practice was not monitoring the number of patients who had managed to stop smoking as a result of the advice given

The practice offered cervical screening with an uptake of 81% of eligible patients. Bowel screening was offered however, the practice could not provide information on uptake.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Latest figures showed the number of eligible children receiving immunisations at two and five years of age were 87% and 79% respectively over the last quarter.

Flu vaccinations had been given to 69% of over 65 year olds over the previous year and 50% of carers.

HIV testing was available and patients living with HIV were signposted to community support services.

The practice provided a wide range of information on health issues. This included information on sexual health services and healthy living so patients could make informed decisions about their health and lifestyle.

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 2014 national GP patient survey and a patient experience survey conducted by the practice. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 84% of patients rated the practice 'as good.' The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All the patients we spoke with told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. This was reflected in the national patient survey where the practice score was above the CCG average for satisfaction with the level of privacy when speaking to staff at the reception desk.

### Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 79% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were above average compared to the CCG area. The results from the practice's own satisfaction survey showed that 94% of patients said they were satisfied with the information given to them by the GP/nurse about their conditions.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language to ensure they could understand treatment options available and give informed consent to care.

### Patient/carer support to cope emotionally with care and treatment

Patients we spoke to said they were satisfied with the emotional support provided by staff at the practice and this was reflected in the CQC comment cards we received.

Leaflets in the patient waiting room signposted people to a bereavement service. Staff informed us that condolence letters were sent out to patients who were bereaved. Patients we spoke to who experienced bereavement confirmed they had received support from the practice and said they had found it helpful.

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. The needs of the local population were understood and services were in place to meet them. For example, the practice population was predominantly in the 25-45 years age range. To meet the needs of these patients the practice had improved access to services by offering extended opening hours on Wednesday evenings and Saturday mornings to fit around patients work commitments.

Longer appointments were available for people who needed them such as those with long term conditions and patients over 75 years old. All patients over 75 years had a named GP.

The practice used computerised risk tools to identify patients with complex needs. Patients identified were invited into the practice for a review and to plan care that met their needs. The computer risk tools helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

There had been very little turnover of staff during the last two years which enabled good continuity of care and accessibility to appointments with a GP of choice. This was reflected in the national patient survey results where the practice scored in line with the CCG average for patients being able to see their preferred GP.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, the PPG had asked for more clinical related questions in the practices' patient satisfaction survey and requested improvements to the practices' website, both suggestions had been implemented by the practice.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had a high number of homeless patients and those with drug and alcohol problems. The practice provided outreach clinics and clinics at the practice to ensure homeless patients could access primary care services. The practice signposted patients to drug and alcohol counselling services and the lead GP had completed training on Methadone replacement prescribing.

The practice had access to a telephone translation service and practice staff spoke five different languages common to the local area. The practice had a system whereby there was an alert on patients records if an interpreter was needed during consultations. Appointments were extended to 20 minutes for these patients. The practice patient satisfaction survey was offered in the three most common languages spoken in the local area.

The premises and services had been adapted to meet the needs of people with disabilities including lift access to the practice for people using wheelchairs or mobility scooters, and accessible toilet facilities.

### Access to the service

The practice was open from 8.00 – 6.30pm weekdays and 9.00 – 12.00pm Saturdays. Extended hours were available on Mondays until 8.00pm. Appointments were bookable either by telephone or in person however, an online appointment system was not yet in place. Non-urgent appointments were bookable up to two weeks in advance and emergency appointments were available on the same day. Telephone advice and home visits for older patients were also available. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by the 111 out-of-hour's service.

Prescriptions could be requested by telephone or online and were available within 48 hours. Patients could choose to either collect their prescriptions from the practice or a designated chemist.

Patients we spoke to had no concerns around accessing the service. They said appointments were available at times that suited them. This was reflected in the results of the practice's patient experience survey where 78% of respondents were satisfied with the ease of booking an appointment and 86% of respondents satisfied with the convenience of appointments. The 2014 national GP patient survey also showed that the practice scored above the CCG average for ease of getting through to the practice by telephone and the convenience of appointments. The practice was rated 'among the best' (that is in the top 20% of practices) for opening hours.

The practice ran a Hub service on behalf of 10 practices in the local area (A pilot project developed by NHS England, designed to support GPs to deal with a high demand for appointments). The Hub was staffed with GPs from the

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

local area and provided consultations for patients who had been unable to get an appointment. If a patient was unable to get an appointment they could access the Hub and would be seen within 24 hours. The Hub provided an extra 30 appointments daily from 3.00-9.00pm and Saturdays 9.00-3.00pm. A member of the corporate team told us the Hub would also operate on Sundays from December 2014 to improve access further.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their 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 there was a complaints leaflet available at reception to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had needed to make a complaint since registering with the practice.

The practice had received six complaints since October 2013. All six complaints had been recorded, investigated and resolved in line with the practice's complaints policy. There were no outstanding complaints at the time of our inspection.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

The practice had a clear vision to expand its services to meet the needs of an increasing number of patients. To achieve this aim the practice was planning to move to larger premises and had identified quality of care, access to the service and continuity of the clinical team as priority areas on which to focus. We found evidence that the practice had a systematic approach to review and improve these areas through regular clinical, staff and multidisciplinary team meetings.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at 13 of these policies and found they had been reviewed annually and were up to date. Policies we reviewed included consent, safeguarding, infection control, waste management, complaints and prescribing.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice was participating in benchmarking and audit. However, the practice was unable to show us evidence of a systematic approach to improving outcomes for patients through audit.

### Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example the nurse was lead for infection control and the senior GP was the clinical and safeguarding lead. The senior GP was supported by Innovision's clinical director and attended monthly governance meetings. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held monthly. Topics discussed included patient satisfaction, referral data and IT issues. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Clinical meetings were held twice per month.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, staffing, equal opportunities and diversity, and whistleblowing which were in place to support staff. Staff we spoke with knew how to access these policies if required.

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

The practice had gathered feedback from patients through patient satisfaction questionnaires, a suggestion box and complaints received. The practice had developed action plans as a result of patient satisfaction questionnaires and made improvements to the service. For example, the results of the annual practice patient survey showed that 31% of patients were not told when to contact the practice for test results. We saw as a result of this the practice had introduced an information leaflet to be given to patients. However, we found the practice had not responded to comments from patients on the NHS choices website.

The practice had a patient participation group (PPG). The PPG was comprised of 12 patients both male and female and were representative of different nationalities between the ages of 40 and 76 years. The practice was actively advertising for more members including posters promoting the PPG in different languages and leaflets for newly registered patients. The PPG met every two months with the practice and agreed on areas for improvement. For example, the PPG had asked for more clinical related questions in the practices' patient satisfaction survey and requested improvements to the practices' website, both suggestions were being implemented by the practice.

The practice had gathered feedback from staff through staff meetings and appraisal. Staff told us they felt comfortable to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available via the computer system to all staff.

# 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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff records and saw that annual appraisals took place which included a personal development plan detailing staff training needs and timelines for completion. Both clinical and non-clinical staff told us that the practice was supportive of training.

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. For example, an incident involved a hospital letter assigned to the wrong patient record. The incident had been recorded and prompt action taken to rectify the error. The incident had been discussed in a staff meeting to ensure it did not happen again.