Stamford Hill Group Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

We carried out a comprehensive inspection of Stamford Hill Group Practice on 29 January 2015. We rated the practice as 'good' for the service being safe, effective, caring, responsive to people’s needs and well-led. We rated the practice as ‘Good’ for the care provided to older people and people with long term conditions and ‘Good’ for the care provided to, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

We gave the practice an overall rating of ‘Good’

Our key findings were as follows:

- The practice had robust systems in place to manage safety. Incidents were reported and investigated promptly and learning shared widely with all staff. Systems were in place for safeguarding vulnerable adults and children, infection control and medicine management. There were enough staff to keep people safe.
- Patient’s needs were assessed and care was planned and delivered in line with current legislation.
- Staff had received training appropriate to their roles and there were appraisals and personal development plans for all staff.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Patients said they could get an appointment in a reasonable time.
- Complaints were handled appropriately and learning shared widely with all staff.
- There was a clear leadership structure and staff felt supported.

However, there was also one area of practice where the provider needs to make improvements.

The provider should:

- Ensure non-clinical staff receive annual, written appraisals.

Letter from the Chief Inspector of General Practice

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to 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 patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with other practices in the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Survey feedback data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they generally found it easy to make an appointment but noted that an appointment with a named GP could take up to two weeks. Urgent appointments were 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. Evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.	
Are services well-led? The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and 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 it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.	**Good**

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 The practice is rated as good for the care provided to older people. The practice had a lower than average number of older patients with 60 patients on the list. All of these patients had been visited proactively by a GP and had a care plan in place to meet their needs. The practice participated in the Frail Home Visiting LES (local enhanced service) covering the most frail and vulnerable housebound patients over the age of 75. All these patients had an alert on their notes to say that when they contact the surgery, a GP should be notified to make a decision about their care. The practice held monthly multidisciplinary hospital admissions avoidance meetings (including the district nursing and palliative (end of life) care teams) to discuss this group.	Good
People with long term conditions The practice is rated as good for the care provided to people with long-term conditions. The practice had nurses dedicated to the care of patients with long-term conditions. For example, diabetes, asthma and COPD. Specialist nurse clinics for heart failure and diabetes were held on a monthly basis. At the time of our inspection 82% of patients with asthma had had a review in the past 12 months, 90% of diabetics and 82% of hypertensive patients had blood pressure readings of better than 150/90 and 77% of diabetics had cholesterol levels of less than 5mmol/l. Ninety seven percent of COPD patients had spirometry (a test to diagnose lung conditions) in the past year.	Good
Families, children and young people The practice is rated as good for the care provided to families, children and young people. The practice had double the national average of children under five years of age. To meet their needs the practice ran a weekly well baby clinic staffed by a health visitor, two nurses and three GPs. After each clinic, the practice held a multidisciplinary meeting to discuss new births, six week baby checks and all vulnerable children. In addition a health visitor led clinic was held each week to offer advice and immunisations. Family planning services including intrauterine contraceptive device (IUCD) and implant fittings were provided by accredited GPs. Weekly antenatal clinics were held and monthly meetings with midwives, health visitors and GPs to discuss specific patients and facilitate communication with hospital services. The practice proactively offered health consultation to all 17 year old females.	Good

Summary of findings

Working age people (including those recently retired and students) The practice is rated as good for the care provided to working age people. The practice offered 'commuter clinics' from 7.30am three days a week and evening clinics from 6.30pm four days a week. Email contact facilities, electronic prescriptions and online prescription ordering were available through the practice website. Routine health checks were provided for those patients over 45 years of age. At the time of our inspection 84% of patients over 45 had had their blood pressure reviewed.	**Good**	
People whose circumstances may make them vulnerable The practice is rated as good for the care provided to people whose circumstances may make them vulnerable. The practice had 156 adults on their patient list considered to be vulnerable. The practice had identified the most vulnerable 2% of these over 18 years of age. At the time of our inspection 91% had a care plan in place. The practice had reviewed 71% of patients on the learning disability register in the last year. The practice worked with other health care professionals and had held a multidisciplinary team meeting to manage patients with learning disabilities. A Family Welfare Officer held weekly sessions for patients with housing, benefits and other social and financial issues to whom the practice referred patients as necessary.	**Good**	
People experiencing poor mental health (including people with dementia) The practice is rated as good for the care provided to people experiencing poor mental health (including people with dementia). The practice held six weekly meetings with the local community mental health team, consultant psychiatrist and care co-ordinator to review all patients on the mental health register. At the time of our inspection 88% of these patients had had physical health checks in the past year and 83% had care plans agreed. The practice participated in the dementia finding Direct Enhanced Service (DES) and had offered 80 screenings for dementia to date. The practice also had attended an educational meeting with the local dementia champion in which all non-clinical staff attended. The practice also held meetings with a local clinic who provided a service for patients with medically unexplained symptoms. A psychologist from the improving access to psychological (IAPT) service provided support for patients once a week at the practice. The practice offered a child mental health clinic run by a clinical psychologist weekly with whom the practice liaised with to discuss relevant cases.	**Good**	

Summary of findings

What people who use the service say

We spoke with six patients during our inspection and three members of the Patient Participation Group (PPG). We reviewed 17 CQC comment cards which had been completed by patients, data from the 2014 National GP Patient Survey, and the practice patient participation survey conducted in 2013/14.

Data from the 2014 National GP Patient Survey showed that 95% of respondents had confidence and trust in the GPs. Patients also rated the practice higher than others for several aspects of care, including their interactions with the GPs and nurses. Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that staff treated patients with kindness and respect, and maintained confidentiality. Patients also commented positively on access to the service, and told us that they were usually able to get an appointment when they needed one. The majority of comment cards reviewed were positive and said the practice offered a professional service, and that staff were helpful and caring.

Areas for improvement

Action the service SHOULD take to improve

Ensure non-clinical staff receive annual, written appraisals.

Stamford Hill Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP, CQC inspection manager and a practice nurse. They are granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Stamford Hill Group Practice

Stamford Hill Group Practice is situated at 2 Egerton Road, London, N16 6UA. The practice provides Primary Medical Services through a Personal Medical Services (PMS) contract to almost 14,000 patients living within the surrounding area. (PMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of the NHS City and Hackney Clinical Commissioning Group (CCG) which comprises 43 GP practices. The patient list is culturally diverse (for example the practice advise that at least 50% of patients are from the local Orthodox Jewish community who have very specific cultural needs). The practice also serves a young population group with double the national average of a children under five years of age.

The practice team comprises six GP partners (three male & three female), four salaried GPs, four female practice nurses and a nurse practitioner who are supported by a team of managerial, reception and administration staff. There is an in-house team of Health Visitors, as well as a visiting physiotherapist and child psychologist attached to the practice. Stamford Hill Group Practice is also a training practice with postgraduate registrars usually working at the practice (postgraduate registrars are fully qualified doctors with considerable hospital experience, who have chosen general practice as their career).

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, family planning and maternity and midwifery services.

The practice opening hours are 8:00 to 18:30 Monday to Friday. Patients who need urgent medical advice outside normal surgery hours can contact an out-of-hours service run by an alternative provider.

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?

Detailed findings

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 29 January 2015. During our visit we spoke with a range of staff including two GP partners, two practice nurses, health care assistant, practice manager and three reception/administration staff. We spoke with six patients who used the service and three members of the Patient Participation Group (PPG). We reviewed 17 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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an incident we reviewed involved a patient who continued to receive anticoagulation therapy in spite of it being contraindicated due to their medical condition. The incident had been recorded, investigated and measures put in place to prevent recurrence.

We reviewed safety records, incident reports and minutes of meetings where these were discussed since 2007. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred since 2007 and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held regularly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example where a patient with a stroke had been anticoagulated the practice had taken steps to recheck the patients international normalisation ratio (INR) level. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by a designated staff member to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. These included alerts relating to the Ebola virus, faulty medical devices and medicine interactions. The practice manager also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. This was confirmed by the meeting minutes we reviewed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Clinical staff were trained to Level 3 in child protection and non-clinical staff to Level 1. All staff had received training in safeguarding vulnerable adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Safeguarding contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with 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 to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy which was visible on the waiting room noticeboard (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). All nursing staff had received chaperone training and criminal record checks via the Disclosure and Barring Service (DBS) were in place for them.

Good

Are services safe?

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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 waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or 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 received annual updates. We saw evidence that representatives from the local Clinical Commissioning Group (CCG) had carried out an infection control audit in July 2014 and that improvements identified for action had been completed on time. For example, we noted that in line with the audit recommendations, the practice had completed a legionella risk assessment.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. 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 to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were 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 carried out a risk assessment for legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in the last 12 months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Good

Are services safe?

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 that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received annual 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (severe allergic reaction) and hypoglycaemia (low blood sugar). Processes were also in place to check whether 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 a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines were disseminated during clinical meetings and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders such as asthma and chronic obstructive pulmonary disorder (COPD). Our review of the clinical meeting minutes confirmed that this happened.

The practice referred patients to secondary care and other community care services in line with national guidance including urgent two week wait referrals for suspected cancer. Referrals made by locum GPs were peer reviewed by the long-term GPs to ensure they were appropriate. The practice had performed in line with other local practices for referral rates, accident & emergency attendances and antibiotic prescribing.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example an audit had been carried out to establish the number of patients over 60 years of age on aspirin but not prescribed Proton Pump Inhibitors (PPIs protect patients from gastrointestinal bleeding when on aspirin). The first audit demonstrated that only 42% of patients on aspirin were also on a PPI. The information was shared with GPs and the patients were reviewed. A second cycle of the audit was completed which demonstrated that 80% of patients on aspirin were now on a PPI.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (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 for the implementation of preventative measures). For example, following an alert from the Medicines and Healthcare Products Regulatory Agency (MHRA) regarding an interaction between amlodipine (a drug used to treat hypertension) and simvastatin (a drug used to treat cholesterol) an audit was carried out to identify patients taking these medicines concurrently and adjust the dose if required. In this instance no patients were identified for a review.

The practice had achieved 89% in their QOF performance in 2013/14 which was below the local CCG and national averages. The practice had identified areas for improvement such as diabetes and hypertension and were investigating why their scores were low.

The team was making use of clinical supervision and staff meetings to assess the performance of clinical staff. The

Good

Are services effective?

(for example, treatment is effective)

staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, referral rates and antibiotic prescribing.

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. We noted a good skill mix among the doctors with GPs having additional training in sexual and reproductive medicine, implants and coil fitting, family planning and GP training. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff undertook annual appraisals that identified learning needs from which action plans were documented. However, we did note that staff appraisals had been missed the previous year due to the practice manager being on sick leave. Our interviews with staff confirmed that the practice was proactive in providing training. Staff told us that any training requested was provided. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology, family planning and contraception. Those with extended roles for example, seeing patients with long-term conditions such as asthma, were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings on a monthly basis 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 to ensure appropriate care planning was in place.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice had effective systems in place for referring

patients to hospital and other health care professionals. Patients were referred to other services/specialists through the referral facilitation service (a central system where

referrals are checked for appropriateness). We found the practices referral process was efficient and in line with

national guidelines. Patients fed back positively about the referral process. Patients told us during our inspection that the GP's usually referred them promptly when it was needed.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw meeting minutes where the Mental Capacity Act 2005 had been a topic of discussion to ensure GPs were up to date with this important legislation.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies (these are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability who were offered annual physical health checks. Practice records showed 71% had received a check up in the last 12 months.

The practice's QOF performance for cervical screening in 2013/14 was 85%, which was below others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was below average for the CCG. The GPs told us that the poor immunisation rates were due to cultural beliefs of the local Orthodox Jewish community which represented over 50% of the patient population. The practice was taking steps to improve uptake through a variety of initiatives which included attending local Jewish health forums and women's groups and providing education.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and a survey of 208 patients undertaken by the practice's patient participation group (PPG) in 2013. The evidence from 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 the practice scored 95% in terms of patients having confidence and trust in the last GP they saw. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at treating them with care and concern and 93% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and the majority 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. Two comments were less positive where patients had expressed difficulty with getting appointments. We also spoke with six patients on the day of our inspection. All 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 saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

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 84% of practice respondents said the GPs involved them in care decisions and 91% felt the GPs were good at explaining treatment and results. Both these results were above average compared to the CCG area.

Patients we spoke with 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 speak English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with during our inspection said the practice staff helped them to access support services to help them manage their treatment and care when it had been needed.

This was reflected in the comment cards we received which highlighted that staff responded compassionately when they needed help and provided support when required.

Information in the patient waiting room and on the patient website told patients how to access a number of support groups and organisations. The practice's computer system

alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Patients we spoke with who had had a bereavement told us they had received emotional support from practice staff 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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, over 50% of the practice population were from the local Orthodox Jewish community. To meet their specific needs the practice offered early Friday appointments before the beginning of Sabbath on Friday evening.

The practice used risk profiling to deliver the unplanned admissions Enhanced Service (ES) which had been introduced to reduce unnecessary emergency admissions to secondary care. The requirements of the ES was to proactively manage 2% of at-risk patients over 18 years of age. At the time of our inspection the practice had completed care plans for 91% of these patients.

The practice engaged regularly with Public Health and the Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised. The practice also met with elders of the Orthodox Jewish community, Jewish health forums and womens groups to discuss their specific needs.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This included improved telephone answering, new telephone system, more on the day appointments to meet the needs of children and training for receptionists in customer care.

Tackling inequity and promoting equality

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

The practice had access to an online interpreter service for those patients whose first language was not English to help them with their communication needs.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity was regularly discussed at staff meetings.

The premises and services had been adapted to meet the needs of patient with disabilities including easy access for wheelchairs to all of the public areas of the practice, and modified toilet facilities including baby changing facilities. A wheelchair accessible lift was available to access the first floor.

Access to the service

Appointments were available from 08:00am to 6:30pm on weekdays. The practice also offered a limited number of appointment slots before 08:00am and after 6:30pm during the week. Urgent appointments were available on the day and anyone with a genuine urgent need would be seen as soon as possible. Patients were able to book a routine appointment however for an appointment with a preferred GP patients told us the wait could be up to two weeks.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made by a named GP and to those patients who needed one and telephone consultations available.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice's extended opening hours three days a week from 7:30am and from 6:30pm four days a week which was particularly useful to patients with work commitments.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the practice leaflet located at reception. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received 14 complaints since April 2013. We reviewed a random selection of these and found they had been promptly investigated and dealt with to the satisfaction of the complainant. For example, one complaint was from a patient who had not been offered a choice of hospital on referral. The practice had arranged a meeting with the patient to discuss their needs. The practice apologised and the patient was referred to their hospital of choice.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Its strategy was to become part of a GP federation in Hackney. The practice had a statement of intent which was displayed in the patient waiting area which set out the practice's aims to provide online facilities by 31 March 2015.

We spoke with three 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 on the desktop on any computer within the practice. We looked at eight of these policies and procedures including policies for safeguarding children and adults, infection control, prescribing and medicine management. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a lead GP for safeguarding. We spoke with three members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice had performed below the local CCG and national averages in the year 2013/14. The practice had identified areas for improvement such as diabetes and hypertension and were actively engaged in improving their performance.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit had been carried out to establish the number of patients over 60 years of age on aspirin but not prescribed Proton Pump Inhibitors (PPIs protect patients from gastrointestinal bleeding when on aspirin). The first audit demonstrated that only 42% of patients on aspirin were also on a PPI. The information was shared with GPs and the patients were reviewed. A second clinical audit was completed which demonstrated that 80% of patients on aspirin were now on a PPI.

Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. These included risk assessments for fire, legionella and the general environment.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. These included clinical meetings, governance meetings, reception meetings and whole practice meetings. 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.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction and recruitment policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the practices annual survey completed in 2013/14 and found 56% of patients were satisfied with the speed of telephone answering which was an improvement on the previous year's survey performance of 34%. We found that the number of patients rating the respect shown for privacy as "excellent" had risen to 38% from 21% since the previous year's survey.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG included representatives from various age ranges, religious and ethnic backgrounds. For example, ages ranged from 44 to 86 years and there were representatives from the local Orthodox Jewish community. The PPG had carried out annual surveys and met at regular intervals. The practice

Are services well-led?

Good

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

manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that when they had asked for specific training it was always provided. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that regular appraisals took place annually. However, we found that staff appraisals were missed last year because the practice manager had been on sick leave. We were told that appraisals would be completed as soon as possible. Staff told us that the practice was very supportive of training.

The practice was a GP training practice with up to two postgraduate registrars working at the practice at any one time. All the GPs at the practice provided training input for the registrars.

The practice had completed reviews of significant events and other incidents and shared the learning from them with staff at meetings to ensure the practice improved outcomes for patients.