The Medici Medical 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

Contents

Overall summary

We carried out an announced comprehensive inspection at Medici Medical Practice on 27 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should:

- Display signage in different languages in the reception area which informs patients of the translation service available.
- Develop a more systematic approach to conditions such as diabetes, mental health including physical health, depression and hypertension to achieve and demonstrate improved health outcomes in these areas.
- Ensure that systems to identify children and vulnerable adults are known and used by all staff.
- Ensure that all staff receive training on the Mental Capacity Act 2005.
- Ensure that all staff complete the safeguarding training as arranged.

Summary of findings

- Ensure that medicines which are not for use in emergency are stored in a locked cupboard
- Ensure that infection control cleaning schedules and audit are updated and completed as planned.
- Ensure that fire training is completed for all staff as arranged.
- Ensure that audit cycles are complete having been reviewed and revisited to determine if actions have been effective.
- Ensure that all staff receive infection control update training
- Ensure that infection control cleaning schedules and audit is updated and completed as planned.

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 at or above average for the locality in some areas and that those that were not these were being addressed. Staff referred to guidance from National Institute for Health and Care Excellence 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 whilst some training was outstanding there were plans in place to address this. 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. 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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment although this took longer if they specified a named GP. There were able to access urgent appointments the same day when necessary. The practice had good facilities and was well equipped to treat patients

Summary of findings

and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for some conditions commonly found in older people and those where the practice identified gaps were discussed and addressed. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met for some conditions although for conditions such as diabetes achievement had been recorded as below average for the CCG. The practice was addressing this and anticipated a better achievement following the measures introduced. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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

Summary of findings

working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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). Whilst the practice were aware that a more systematic approach is required to address the physical health of people experiencing poor mental health they were addressing this and had developed links with other services to improve care for this patient group. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection and we also spoke with the chair of the patient participation group (PPG). We looked at comment cards that patients had left at the practice and saw that all of the 14 comments cards contained positive comments. Patients reported receiving excellent care from doctors and that all staff were efficient, helpful and polite.

Patients told us they were treated with respect and had their dignity maintained. They told us that doctors took time to explain their condition and allowed them time to ask questions. Patients told us that they found it helpful to be able to access female doctors when they needed to.

The PPG chair reported that the practice had been responsive to the views of the group and had listened and worked with them to improve services. They provided examples of how the practice had introduced new systems to improve services for patients and had provided demonstrations to the PPG to allay their concerns regarding sharing of information.

Areas for improvement

Action the service SHOULD take to improve

- The practice should display signage in different languages in the reception area which informs patients of the translation service available.
- The practice should develop a more systematic approach to conditions such as diabetes, mental health including their physical health, depression and hypertension to gain a higher achievement of health outcomes in these areas.
- The practice should ensure that facilities to identify children and vulnerable adults are known and used by all staff.
- The practice should ensure that all staff complete the safeguarding training as arranged.
- The practice should ensure that all staff receive training on the Mental Capacity Act 2005.
- The practice that medicines which are not for use in emergency are stored in a locked cupboard.
- The practice should ensure that fire training is completed for all staff as arranged.
- Clinical audit cycles should be reviewed and revisited to determine if actions have been effective.
- The practice should ensure that all staff receive infection control update training as planned.
- The practice should ensure that infection control cleaning schedules and audit is updated and completed as planned.

The Medici Medical 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 and a specialist advisor who was a trained nurse.

Background to The Medici Medical Practice

Medici Medical Practice provides a range of primary medical services to approximately 11,850 patients in central Luton under a personal medical services contract (PMS). It is a training practice which provides support and mentorship to doctors training to be GPs. The practice population has a number of patients from different ethnic backgrounds, predominantly Asian and Eastern European and a significantly higher than average number of patients in the 0-4 years and 25-35 years age groups.

There are two GP partners, one male and one female. There are four salaried GPs both male and female. The practice employs four nurses, two of whom treat minor illness and two practice nurses who deal with long term conditions and general practice nursing. There are also two health care assistants and a practice manager who is supported by a number of reception and administration staff.

The CQC intelligent monitoring placed the practice in band 1. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

When the surgery is closed out of hours care is through the Care UK provider.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- 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 27 November 2014. During our visit we spoke with a range of staff including, GPs, practice nurses, health care assistant, reception and administrative staff, the practice manager and trainee GPs. We also spoke with patients who used the service and observed how they were dealt with by staff during their visit to the practice. Prior to our inspection we spoke with the chair of the patient participation group who shared the views of the group regarding the engagement of the practice with them.

Good

Are services safe?

Our findings

Safe track record

We saw that 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, we saw documentation of an incident regarding prescribing. We saw that this had been documented and investigated and lessons learned and shared with staff.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. We saw that the practice managed these appropriately and learnt from them and that outcomes and learning was shared with all staff at meetings.

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 during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda and we saw minutes from practice meeting which confirmed these were discussed. 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, told us that they knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. They reported experiencing a no blame culture within the practice.

We saw evidence of action taken as a result of reporting incidents, for example staff training and awareness of violence and aggression procedures following a violent incident where patients and staff could have been affected. All staff were made aware of the panic buttons in the practice and what to do if they were activated.

National patient safety alerts were disseminated by email to all appropriate practice staff via the practice manager. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the clinical meeting if relevant to ensure all staff were aware of any action they needed to take.

Reliable safety systems and processes including safeguarding

We looked at staff training records which showed us that more than half the staff had undertaken safeguarding training but that some were still outstanding. However, on the day of our inspection training was taking place at the practice and we saw that a number of staff attended that day. The practice manager told us that any staff who had not been able to attend were scheduled for March 2015 training. Following our inspection the practice manager submitted evidence to show that training had been arranged for February and March 2015 for all remaining staff.

Staff we spoke with were able to demonstrate how they would recognise signs of abuse in older people, vulnerable adults and children. The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw that the practice kept a list of vulnerable patients, for example those with learning disabilities and those requiring palliative care so they were able to identify those patients immediately to ensure they addressed any issues or unmet needs.

GPs we spoke with told us there was a facility on the clinical system which flagged children who were at risk but if any children were considered at risk they would be discussed at the practice meeting. However, nurses we spoke with reported that there was no way of highlighting children at risk on the system but confirmed that any patients at risk would be discussed at meetings and informal discussion would take place with the health visitor. The practice had identified a GP safeguarding lead; however, some staff we spoke with were not sure who this was. They were 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. Contact details were easily accessible. Following our inspection the practice manager submitted evidence to demonstrate that all staff had been made aware of the safeguarding lead.

Patients told us that they were offered a chaperone when required. There was a chaperone policy, which was visible

in consulting rooms. (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 been trained to be a chaperone.

Medicines management

During our inspection we checked how medicines were stored in the treatment rooms and medicine refrigerators. Medicines that the practice had decided to keep were stored in the nurses' treatment room. This was a lockable room and the medicines were stored away out of sight. However, the cupboard was lockable on one side only and the medicines were stored in the unlocked side. The practice were made aware of this and following our inspection the practice manager told us that these had been transferred and were now stored in the locked side of the cupboard.

The practice had an appropriate system in place to check medicines and we saw that they had been checked regularly and signed for. However, we found one pack of adrenaline which was out of date. The practice removed this immediately. Following our inspection the practice manager contacted us and informed us that they had investigated and had identified how this had occurred. They told us they had assured themselves that the current system was adequate and appropriate. We saw a clear process for ensuring that medicines were kept at the required temperatures and saw records to show that the refrigerator temperature was checked and monitored daily.

The practice told us that they reviewed prescribing data and had meetings with the pharmacist. For example, we saw that recently they had reviewed their prescriptions for dressings and discussed this at a practice meeting.

The nurses 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 which were kept electronically and evidence that nurses had received appropriate training to administer vaccines in September 2014. Two members of the nursing staff were qualified as independent prescribers. We spoke with one of them who reported good supportive relationships with the GPs at the practice and told us they received regular informal supervision.

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.

The practice had a protocol for repeat prescribing which was in line with national guidance. Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. There was an independent pharmacy located on site at the practice which enabled prescriptions to be obtained easily. Patients told us they found this a useful and convenient facility.

Cleanliness and infection control

The practice manager was the lead for infection control and had undertaken training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and received annual updates. We saw from the training record that not all staff had undertaken infection control update training which had been arranged for February 2014 and the practice manager told us this was in progress. The practice should ensure that this is completed as soon as possible. There was an infection control policy in place for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. However, some practise was not in line with this policy. For example, we saw evidence of only one audit and whilst we were told there was a cleaning schedule being developed, this was work in progress and not being completed at the time of the inspection. However, we observed the premises to be clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Following our inspection the practice manager contacted us with details of an audit that had been commenced and confirmed they were working with infection control leads at the CCG to determine an efficient and useful system to implement. They also provided us with a cleaning schedule had been in use following the day of inspection.

We saw that there was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Good

Are services safe?

There were 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 a policy for the management, testing and investigation of 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example electrocardiograph machines and blood pressure measuring devices.

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).

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. The practice had a holiday policy in place to inform staff of the arrangements 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 demonstrated that they had monitored risks to patients, staff and visitors to the practice. These included regular 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.

The practice had recently become involved in a pilot scheme for patients with mental health problems. This involved the practice being able to refer patients to receive a counselling service, alcohol and substance misuse advice and support from the community mental health team and referral to improving access to psychological therapies (IAPT).

The practice monitored repeat prescribing for people receiving medication for mental ill-health. For example, the practice told us that when a patient with mental health problems requested a repeat prescription for antipsychotic medicines then this would trigger a review.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support in July 2014. Emergency equipment was available behind the reception desk 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 and hypoglycaemia. We saw there was a process 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 except for one box of adrenalin found in the nurses' room. Following our inspection the practice manager notified us that this had been investigated and the reason for this was identified, addressed and the risk of this recurring had been mitigated.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Good

Are services safe?

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.

We saw evidence that the practice carried out a fire risk assessment quarterly which included actions required to maintain fire safety, however, there was no evidence to demonstrate that any fire training had been undertaken or fire drill carried out. The practice manager told us that they were assured that staff had undertaken training but that they did not have the certificate to demonstrate this. Following the inspection the practice manager contacted us to inform us that training was being arranged.

Medical staff told us that they had received an induction which included safety issues, such as fire, resuscitation and awareness of the location of panic alarms and what to do if they were activated.

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 guidance was disseminated electronically as well as via the clinical meetings. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, there was feedback from the local clinical commissioning group on local needs. 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 practice had GP leads for specific areas such as dementia and mental health until recently when some doctors had left. The GPs told us that they had now allocated a lead to mental health and diabetes roles to improve outcomes for those patients. We spoke with the practice nurses who told us that they carried out care specifically in diabetes and chronic obstructive pulmonary disease (COPD) and supported the doctors in their work in chronic disease management 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. We observed a supportive and engaging ethos throughout the practice and noted that the GPs were providing a teaching session to support new doctors during our inspection.

The GPs we spoke with told us that data from the local CCG of the practice's performance in prescribing was discussed at meetings with the pharmacist. The practice had recently reviewed prescribing for dressings and taken appropriate action. The practice completed a review of case notes for patients with high blood pressure which was triggered by repeat prescription requests. These were reviewed and adjusted to take into account age and co-morbidity. The practice used computerised tools to identify patients with complex needs such as diabetes and respiratory diseases and developed care plans using their own template. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

The GPs reported that they used national guidelines and clinical judgement to support their referral decisions and the CCG feedback to the practice on referral data was discussed at clinical meetings to highlight and address any anomalies. We saw minutes from meetings where regular reviews of elective and urgent referrals were made and that improvements to practise was shared with all clinical staff. For example, we saw that GPs had visited, called or sent letters to mental health patients who had become homeless. There had also been an audit of patients who had frequently attended A&E which was shared at the practice meeting.

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

The practice demonstrated an effective general approach to care although had identified some issues with the physical care of patients with mental health problems and diabetes. Patients with mental health problems were seen by GPs only but there was no formal system for monitoring the physical health of patients with severe mental illness. The practice had access to an outreach service from a mental health consultant who attended the practice once a month to see patients requiring specialist treatment. Patients experiencing mental health problems were identified on a register that allowed the practice to identify those patients taking medicines requiring regular review.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management. The GPs told us clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common

Good

Are services effective?

(for example, treatment is effective)

long-term conditions and for the implementation of preventative measures). The QOF areas were used as a trigger for reviewing what work needed to be done to achieve targets which were not being met. For example, diabetes and mental health. The practice showed us one clinical audit that had been undertaken in the last year by the trainee doctors regarding ACE inhibitors but did not demonstrate that it had been reviewed, therefore was not complete.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice were aware that they had not achieved the optimum outcomes for patients with diabetes and mental health problems and were an outlier in some areas of diabetes, blood pressure and mental health clinical targets. They had recruited a new GP who was to commence in January 2015 who they anticipated would help improve achievement. They also identified that they needed a more systematic approach to chronic disease management.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice around quality and improvement and it was clear from practice minutes that they were committed to improvement. The practice had recently addressed access issues by piloting the introduction of a telephone triage service and was monitoring the effectiveness of this system.

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. 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 had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Staff meetings included attendance by the MacMillan Nurse, health visitor and district nurse.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with annual basic life support training, but there was no evidence of fire training having been carried out in the last year.

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).

All staff told us that they received annual appraisals that identified learning needs from which action plans were developed. However, not all appraisals had been completed at the time of inspection for this year. Staff we spoke with told us that they felt they could identify training needs at any time and were supported to develop. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

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 and long term conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. The practice told us that the consultant psychiatrist visited the practice monthly to see patients with mental health problems. A diabetes specialist nurse also attended the practice to provide advice to staff and support patients whose condition was more complex.

The practice 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

Good

Are services effective?

(for example, treatment is effective)

electronically. The GPs were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required and would initiate the appropriate recall. 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 GPs told us that the practice had a training culture which aimed to discuss how to deal with borderline laboratory results and uncertainty.

The practice had taken up the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the practice were adopting systems to identify patients at high risk of attendance to A&E and communication was working well in this respect.

The practice held multidisciplinary team meetings weekly 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, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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, the walk-in centre and community clinics to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015 depending on patient consent. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record called SystmOne 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 clinical staff were aware of the Mental Capacity Act (MCA) 2005, the Children Acts 1989 and their duties in fulfilling it. The practice had not received training on the MCA but GPs had arranged a session on this from the local psychiatrist. 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.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. The practice had allocated a GP as lead for dementia. Care plans were recorded on SystmOne for patients with dementia, learning disabilities and those patients at high risk of admission to hospital. Staff we spoke with 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).

The practice did not carry out minor surgical procedures but demonstrated an awareness of the need to gain and record verbal or implied consent for any other invasive procedures for example, cervical cytology.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had met with the CCG to discuss the implications and share information about the needs of the practice population and local area.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a health check with the health care assistant (HCA) to all new patients registering with the practice and was trained to know when to refer appropriately to the GP. The GP was informed of all health concerns detected and these were followed up in a timely way. The HCA also carried out the health checks offered to all patients aged 40-75years. There was evidence that a GP had addressed issues regarding raised blood pressure and high cholesterol arising from health checks.

The practice recorded smoking status and offered a smoking cessation service where the HCA provided advice and support to patients wishing to stop smoking. There was a register of patients with learning difficulties and the practice offered annual physical health checks to these patients. The practice also offered patients help and support with weight management and provided an opportunity for patients to discuss medical treatments for weight management with the GP when appropriate.

The practice's performance for cervical smear uptake was 81%, which was better than others in the CCG area. The practice had a policy which was in line with the national guidance for cervical screening programme which ensured that staff were appropriately trained and there was a system in place for call and recall of patients and that an audit of inadequate sample rates. They also provided chlamydia screening.

The practice offered a full range of immunisations for children in line with national recommendations and a medical examination at eight weeks when the doctor examined the baby and the first immunisation was given. Last year's performance for all immunisations at age 12 months was 92% just below the CCG average of 95%. Travel vaccines and flu vaccinations were also offered in line with current national guidance. The practice visited those patients who were housebound to provide them with their flu vaccination.

All patients over the age of 75 had their own named GP. The practice had identified a lead GP for dementia and there were care plans being developed for those patients on the register as well as for those with learning disabilities and those at risk of unplanned admission.

Patients with long term conditions were called for annual review and the practice had an above average achievement in COPD but the practice acknowledged that a more systematic approach to conditions such as diabetes, mental health, depression and hypertension could result in a higher achievement of health outcomes in these areas. The practice had input from the specialist diabetes nurse who attended the surgery and the local psychiatrist for those patients with mental health problems.

The practice held multidisciplinary meeting with the MacMillan nurse and district nurse and had a co-ordinated approach to end of life care.

We saw evidence of signposting to other agencies such as the drug and alcohol advisory service, British Pregnancy Advisory service and mental health support services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with eight patients and reviewed the information from the national patient survey and comment cards that patients had left at the practice for us. Patients we spoke with told that they found all staff treated them with respect and maintained their dignity. The reception desk was enclosed by glass partitions that provided more privacy for patients when speaking to reception staff. Staff told us that if a patient wished to speak in private they could take them to another room.

We observed how staff dealt with patients when they approached the reception desk and noted that the reception staff were polite and helpful. Patients we spoke with also confirmed this. We heard a staff member dealing with a query on the telephone and observed that they gave clear information and were helpful to the patient. We looked at the data from the national patient survey which showed that of 127 patients who responded 88% reported that GPs treated them with care and concern. The patients we spoke with told us they never felt hurried during the appointment and that the GP listened to them and gave them time to ask questions.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and all 14 cards 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. There was only one comment which referred to a longer wait for an appointment if they required a specific GP.

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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Two patients confirmed that their dignity was protected during intimate examinations with screens and a dignity cover and that they had been offered a chaperone at that time. We saw notices in treatment rooms informing patients that a chaperone was available if required. Patients commented on the benefit of having a choice of being able to see a female or a male doctor.

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. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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 85% of practice respondents said the GP involved them in care decisions compared to 78% average of the CCG and 86% felt the GP was good at explaining treatment and results which was in line with the CCG average.

Patients we spoke with on the day of our inspection told expressed satisfaction with both the doctors and nurses regarding their involvement of care. They told us that they were clear and took time to explain their treatment and medication with them and that they felt involved in all aspects of their care. 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.

Reception staff we spoke with told us that translation services were available for patients who did not have English as a first language and explained the process they used to access this. They also told us that they had access to an interpreter for the deaf. Whilst we saw evidence that interpreters were used and could be accessed there were no signs in a different language which advertised this service to patients.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of respondents to the national patient survey said that the GP was good at listening to them. Patients we spoke with gave examples of where the GP had listened and put them at ease, explained their treatment and suggested referral to secondary care. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room also told patients how to access a number of support groups and organisations. For example we saw that there was a carer's board in the waiting room containing information to ensure they understood the various avenues of support available to them. The practice's computer system also alerted GPs if a patient was also a carer

Staff told us that if families had suffered a bereavement, their usual GP contacted them by telephone if appropriate and would follow this up with a visit if necessary.

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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, they had acknowledged that retinal screening was not as well attended as patients had to attend Bedford Hospital, therefore they were investigating the possibility of hosting the service at the practice to improve uptake. They also acknowledged that their uptake for health checks was not as good as they would like and they had agreed to work with another practice that had had success with their approach to improve uptake.

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). For example, the practice noted from patient feedback that it was at times difficult to get an appointment. As a result they are trialling a telephone triage system for patients who call in who need to be seen on the same day. During our inspection this trial was still taking place. Patients and staff we spoke with told us that access to appointments had improved since the introduction of the system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example it was offered access to translation services and they also had access to a sign language translator for those patients who were deaf. However, there was no signage to advertise this to patients whose first language was not English.

The practice provided equality and diversity training through e-learning although we did not see evidence of this in staff records. However, staff we spoke with were able to demonstrate that they understood the principles of equity and diversity.

The entrance to the premises and services had been adapted to meet the needs of patient with disabilities with an approaching ramp for wheelchair access and wide opening automatic doors and a large reception and waiting area allowing easy access for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. There was a lift to the first floor where consultations also took place and there were disabled toilets and toilets with baby changing facilities.

Access to the service

Appointments were available from 6.30am to 8pm on Tuesdays and Wednesday providing extended hours appointments. They offered appointments from 8am until 6pm on Mondays, Thursdays and Fridays. They also offered additional extended hours appointments on Saturdays from 8.30am until 12.30pm. Patients were also able to access a GP urgently on the day using the telephone triage service which was being trialled.

Comprehensive information was available to patients about appointments on the practice website. 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 to those patients who needed one.

We spoke with patients who were attending the practice that day who were generally satisfied with the appointments system. They commented that they were able to get appointments when they needed one but that they may have to wait if they specified a GP. They told us that if they needed an appointment urgently they could usually be seen.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

We saw that 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. The practice told us that the practice manager was the designated responsible person who handled all complaints in the practice.

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.

We looked at complaints received in the last 12 months and found they had been handled satisfactorily and dealt with in a timely way. We saw that they had been discussed at practice meetings and any actions or changes implemented as a result. The practice carried out an annual review but had not identified any common themes.

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. The GPs told us of their current vision and future plans and staff we spoke with were clear about the vision for the practice. The GPs partners were still exploring ideas regarding succession planning. Staff told us that the vision was shared at the clinical meeting and that they felt valued and listened to. However, whist all staff were aware of the vision it was not written into a visible plan. The practice may find it useful to develop a written strategy to help to track and measure their progress towards this.

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

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 a selection of these policies and procedures and saw that they had been reviewed two years ago. We saw that the governance lead had been involved in this process and that policies were discussed at practice meetings.

The practice told us that governance was an integral part of the practice meetings, it was embedded in the agenda, and we saw evidence that performance, quality and risk was discussed.

There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager was the lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with nine 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. They reviewed their performance at regular intervals to determine what areas needed attention. The practice QOF data showed some areas where it was below the CCG average for example, diabetes and mental health. We noted from discussions with staff and minutes from meetings that plans and actions were being implemented to address these areas.

The practice told us that the local CCG cluster groups assist with peer review and they met regularly to discuss this. Audits were carried out as a result of CCG feedback in response to unplanned admissions, A& E attendances, referrals and prescribing.

Clinical audits were used to monitor achievement against QOF but we saw no evidence of a regular audit plan for other areas of clinical care. The practice should ensure that clinicians carry out structured audit at least yearly to monitor quality of care or treatment provided.

We saw that the practice had arrangements for identifying, recording and managing risks. Whilst there was no specific risk log, risks were identified individually for example, significant event log, fire risk assessment. We saw that the risks were discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example safeguarding where training had been arranged to ensure all staff had received the appropriate training.

Leadership, openness and transparency

Staff we spoke with spoke positively about the practice and told us that they felt there was an open and honest culture and that they felt confident that they could raise any issues of concern at any time with the GPs or practice manager. We saw from minutes that team meetings were held weekly.

The practice manager was responsible for human resource policies and procedures and they have access to an external company for advice when required. We saw that policies and procedures were stored electronically and were available for all staff to access at any time. We saw reviewed a number of policies, for example recruitment and induction of nurses. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice had gathered feedback from patients through their patient participation group (PPG), suggestion box in reception and they had a facility online for patients to make suggestions and leave feedback.

We spoke with the chair of the PPG who told us that the group had been formed in January 2014. They reported a commitment from the practice to the group and told us that GPs and the practice manager always attend their meetings and there was good communication between them. They told us that the practice were responsive to their concerns and views, for example, when the practice wanted to introduce the triage system, the PPG were concerned about the risk. The practice agreed to trial the system and review it to determine whether there were any reported adverse effects on patients. The PPG chair also told us that the practice provided a demonstration of the new SystmOne clinical system as the PPG had expressed concerns regarding transfer of information. They told us that they felt the practice was progressive and yet empathised with concerns patients had.

The practice met every six to eight weeks and minutes were made available on the website for all patients to access. The practice had shared the outcome of a visit from the local Health Watch and the PPG had an opportunity to give their views on the outcomes.

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. Nurses we spoke with told us that they lots of opportunity to develop and they had identified specific training at appraisal which was supported. Nurses also told us they had access to additional courses due to the practice teaching status. 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 in the staff handbook and 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. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice and there are three GPs who are trainers. They provided tutorials every Thursday and we saw that during our inspection this was taking place. We spoke with two new doctors who were at the end of their experience with the practice and they described this as positive and told us they were supported during this time.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients, for example communication with secondary care following poor communication of discharge information.