Hockley 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

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Hockley Medical Practice on 18 June 2015. We have rated this practice overall as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, 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).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice had a system for reporting, recording and monitoring significant events over time.
- Patients' needs were assessed and the practice planned and delivered care following best practice guidance.
- Patients confirmed that the practice helped them manage their long term conditions and had arrangements in place to make sure their health was monitored regularly.
- There was information in the waiting room and on the practice website that offered information about various health conditions, support systems and groups available.
- Hockley Medical Practice was visibly clean and hygienic. The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- Information about how to complain was available and easy to understand.

Summary of findings

However, there were also areas of practice where the provider should make improvements:

- Ensure there is an effective process to manage and monitor action taken as a result of patient safety alerts.
- Ensure all staff are aware of the role of a chaperone and how to effectively fulfil the role.
- Ensure minor surgery audits are carried out.
- Ensure appropriate recruitment processes are followed including obtaining references when new staff members are recruited.

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 to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Equipment required to manage foreseeable emergencies was available and was regularly serviced and maintained.

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. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Clinical audits were carried out and changes made to ensure patient care was appropriate for their needs. The findings from some audits resulted in changes to patients' prescribed medicines. There was evidence of multi-disciplinary working. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

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 most aspects of care. Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The comment cards patients had completed prior to our inspection provided positive opinions about staff, their approach and the care provided to them. 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. Patients had access to screening services to detect and monitor certain long term conditions. There were immunisation clinics for babies and children. The practice had recognised through patient surveys and feedback that access to appointments was an issue but had responded. The practice had good facilities and was well

Summary of findings

equipped to treat patients and meet their needs. If patients were unable to attend the practice, a home visit could be arranged. The practice had a system in place to respond to complaints and concerns.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy to increase its size. 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 was evidence of improvements made as a result of feedback from patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. 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 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. The GPs and nursing staff worked together 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. Practice staff held a register of patients who had long term conditions and carried out regular reviews. For patients with the most complex needs, GPs 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 accident and emergency (A&E) attendances. All consultation rooms were on the ground floor which made the practice accessible for pushchairs and appointments were available outside of school hours. There were policies, procedures and contact numbers to support and guide staff should they have any safeguarding concerns about children. The clinical team offered immunisations to children in line with the national immunisation programme. Immunisation rates were comparable to local and national average.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered extended opening hours to assist this

Summary of findings

patient group in accessing the practice. NHS health checks were available for people aged between 40 - 74 years. The practice offered a range of health promotion and screening services which reflected 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. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and all of these patients had received a follow-up where issues were identified. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. GPs carried out home visits on request to patients who were unable to attend the practice. The practice had access to interpreting service for patients whose first language was not English.

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). Care was tailored to patients' individual needs and circumstances including their physical health needs. The practice offered annual health checks to patients on the mental health register. Practice staff worked in conjunction with the local mental health team to ensure patients had the support they needed. Both GP partners had attended training in the Mental Capacity Act 2005 to ensure all care provided was in patient's best interests. Patients with dementia were offered longer appointments.

Summary of findings

What people who use the service say

We reviewed the 33 patient comment cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. Patients who had completed these comment cards had written positive comments. These included that the staff were very nice and helpful and that the clinical staff listened to them and were pleasant. Whilst all the comments cards were positive about the service and treatment received at the practice, six patients who completed comment cards also stated that access to appointments could be improved.

We looked at results of the latest national GP patient survey which was published January 2015. Out of the 461 surveys, 89 were completed and returned, representing a completion rate of 19%. Findings of the survey were also compared to the average for practices in the local Clinical Commissioning Group (CCG) and the national average. A CCG is a group of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The results of the national survey showed the practice was above average for most areas. For example, 98% of respondents had confidence and trust in the last GP and nurse they saw or spoke to compared to the local and nationl average of 92% and 95% respectively. Ninety two percent of respondents said the last GP they saw or spoke to was good at treating them with care and concern. This was above local and national average of 80 and 85% respectively.

We spoke with three patients on the day of the inspection and we spoke with the chair of the Patient Participation Group (PPG), after the inspection on the telephone. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. Patients provided positive feedback regarding the staff and the service. All patients confirmed that they were treated well, with dignity and respect by all staff at the practice. The chair of the PPG confirmed that the practice listened to the group and made changes where appropriate to improve service.

Areas for improvement

Action the service SHOULD take to improve

- Ensure there is an effective process to manage and monitor action taken as a result of patient safety alerts.
- Ensure all staff are aware of the role of a chaperone and how to effectively fulfil the role.
- Ensure minor surgery audits are carried out.
- Ensure appropriate recruitment processes are followed including obtaining references when new staff members are recruited.

Hockley Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Hockley Medical Practice

Hockley Medical Practice is a registered provider of primary medical services with the Care Quality Commission (CQC). The surgery served a population of approximately 5800 patients. The practice is open Monday to Friday 8.30am to 6pm except Wednesdays when it closed at 12.30pm at this time the service is delivered by another provider (Primacare). Extended early opening hours are offered on Tuesdays from 7.30am. Late opening hours are offered on Thursdays until 7.30pm. The practice has opted out of providing out-of-hours services to their own patients. This is provided by an external out of hours service.

There are two GP partners (one male and one female) and a locum GP. There is also a trainee GP as it is a training practice and both GP partners are trainers. There is a practice nurse, a healthcare assistant, a practice manager and a team of reception staff.

The location of the practice (near the centre of Birmingham) meant that the practice has a mix of patients from various backgrounds. Data we looked at showed that that practice is located in a highly deprived area. However, one of the GP partners and other staff told us that they have a mix of patients registered at the practice from deprived to professionals working in the city. The practice has a higher than the national average patients aged between 20 and 39. The practice has a population of 50 to 85 year olds which is lower than the national average.

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.

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?

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:

Detailed findings

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

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 18 June 2015. During our inspection we spoke with a range of staff including the GP partners, a trainee GP, a practice nurse, a health care assistant, the practice manager and two reception staff. We also spoke with four patients including the chair of the PPG and we received 33 comment cards from patients. We observed how patients were being cared for and staff interactions with them. Where necessary we looked at care and treatment records of patients. Relevant documentation was also checked.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. We reviewed safety records and incident reports dating back to December 2013 which showed that the practice had managed them consistently over time. Staff members we spoke with told us that they informed the practice manager after an incident and the practice manager would complete an incident form. We saw evidence of action taken as a result incidents to prevent any reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of eight significant events that had occurred during the last two years and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda which were held monthly to review actions from past significant events and complaints. For example, we saw that an incident that had occurred in November 2014 was discussed in the January 2015 meeting. This was in regards to a panic alarm being activated by a staff member requesting assistance with a patient. It was found that the buzzer was not loud enough and a new system would need to be installed by contractors. Staff were advised to use their personal alarms as well as the alert system on the practice computer system. This showed that the practice had learned from incidents, findings were shared with all staff and action taken.

National patient safety alerts were disseminated by the practice manager to all clinical staff. We saw a folder with relevant alerts that were documented as being forwarded to appropriate clinicians by the practice manager. Although there were no documented actions that were taken as a result of the alerts staff we spoke with were able to give examples of recent alerts that were actioned. For example, we saw evidence Medicines and Healthcare products Regulatory Agency (MHRA) alerts were responded with appropriate actions taken.

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. 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 safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible as they were displayed the consultation rooms we looked in as well as in other staff areas such as the reception.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level 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. Staff records looked at showed that they had also received appropriate training for their roles.

We saw evidence of 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.

The staff we spoke with could clearly demonstrate the action they would take if they had concerns in relation to a patient who did not attend an appointment. We saw safeguarding was a standing agenda on the monthly practice meetings. For example, from the minutes of staff meeting in March 2015 we saw that a safeguarding issue was discussed and updates provided to staff members.

There was a chaperone policy, which staff could access through their shared policy system. 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. Signs informing patients of their right to have a chaperone present during an intimate examination were on display in various parts of the practice including consultation rooms. Staff members we spoke with told us that the healthcare assistant (HCA) acted as a chaperone

and administration staff were asked only as a last resort. Administration staff we spoke with did not demonstrate appropriate understanding of their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. They also confirmed that they had not received any training for the role of chaperone. Disclosure and Barring Service (DBS) checks were not completed for these staff. However, the practice manager showed us evidence that they had applied recently. DBS checks help to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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. We spoke with the practice nurse who was responsible for monitoring medicines and they told us that they had access to an immunisation's co-ordinator at Public Health England (PHE) for any advice.

Records showed and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature. 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were used in the practice. Locum GPs and GP registrars did not have ready access to hand written prescriptions although they could access them from the GP partners if requested. We found that the practice did not have a system in place to record and monitor prescription numbers. We brought this to the attention of lead GP at the time of our inspection and the provider agreed to take action.

Cleanliness and infection control

The practice was located in purpose built premises built within the last four years. We observed the premises to be visibly clean and tidy. The practice had an external cleaner and we saw there were cleaning schedules in place. However, cleaning records were not kept. The practice manager told us that the external company carried out monthly spot-checks. Although we did not see evidence of the checks we saw documented evidence where the practice manager was asked to provide feedback as part of these checks. We spoke with four patients who told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had an infection control policy with a named lead. We spoke with the lead who had started recently and was still developing in their role and had not fully assumed the role of the infection control lead. We saw evidence of an infection control audit that had been carried out by a previous staff member in April 2015. Actions identified were being actioned by the practice staff.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with touch free taps (in toilets), 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 which can contaminate water systems in buildings). We saw that the policy stated that it was the 'duty holders' responsibility to carry out a legionella risk assessment. The practice was unsure who the 'duty holder' referred to in the policy was and could not produce a risk assessment when asked. The practice manger showed us some actions they had been taking to reduce the risk from legionella by running taps and monitoring water temperature in the surgery. After the inspection the practice confirmed that they were organising a risk assessment to be undertaken by a contractor.

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. We saw records that demonstrated all portable electrical equipment had been tested to ensure they were safe to use. We saw records that demonstrated that all medical devices had been calibrated in July 2014. This included devices such as weighing scales, nebulisers, spirometer and blood pressure measuring devices.

Good

Are services safe?

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for most staff. For example, proof of identification, references, qualifications and registration with the appropriate professional bodies. However, we saw one staff member recently recruited did not have references in place although there was evidence that the practice had asked appropriate referees. The practice manager told us that they would ensure this was chased up.

We saw that criminal records checks through the Disclosure and Barring Service (DBS) were in place for clinical staff. DBS checks help to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We saw evidence that the practice had applied to undertake DBS check for administration staff also.

We were told that one of the challenges the practice had faced over the last couple of years was around appropriate staffing levels. A longstanding nurse had left in February 2014 and the practice was unable to recruit until October 2014 putting extra pressure on the GPs to cover the nurse's roles such as reviews of long term conditions. A new GP partner had joined and the practice was looking to appoint a locum GP.

The practice had recruited three new reception staff in the last year. We were told that the practice had not had adequate staffing in the reception over the last couple of years. Although staff said that the level of staffing had not significantly impacted on the level of care provided to patients, it had put a considerable amount of pressure on existing staff members and their morale. One of the reception staff recruited was still undergoing training but the practice manager felt that they could now work proactively to offer a better service to patients rather than being reactive.

Monitoring safety and responding to risk

We saw policies were in place to support health and safety. Health and safety information was displayed for staff to see and staff were aware of how to report risks and who to report them to. The practice manager was able to share records of fire alarm maintenance tests carried out by an accredited and approved fire alarm specialist to ensure that the fire alarm and sensor was in working order and that staff and patients were not at risk. We also saw records of electrical testing as well as a health and safety risk assessment.

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.

Emergency medicines were available in a secure area of the practice on a mobile trolley and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (allergic reaction) and diabetes. 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.

Emergency equipment such as oxygen and an automated external defibrillator was kept with the emergency medicines. (An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm).

The practice nurse was responsible for ensuring all emergency medicines and equipment were in good working order. They told us that they regularly checked all emergency medicines and equipment. However, the checks for the AED and oxygen were not documented. The nurse assured us that this would now be done.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. However, the plan was not detailed or robust. For example, the plan had a section on loss of water supply but did not detail any mitigating actions to reduce and manage the risk. It only stated 'any problems contact the water board'. The practice manager agreed to ensure this would be reviewed so that the plan was more robust.

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. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. For example, GPs told us how they had switched patients from one medicine to another as a result of following NICE guidance. Although NICE guidance was discussed by GPs these discussions were not always documented. We saw that the practice followed guidance from the local Clinical Commissioning Group (CCG) on pharmacological management of neuropathic pain in adults. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The GPs told us they led in specialist clinical areas such as asthma, diabetes and heart disease. The practice nurse had started working at the practice from October 2014 and was helping with management of patients with long term conditions.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was lower than similar practices within the CCG. The report also highlighted that the practice was below or on target for prescribing other medicines such as non-steroidal anti-inflammatory drugs (NSAIDS).

The practice had signed up to a number of enhanced services available to practices from the CCG. An enhanced service is a service that is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided included minor surgery and unplanned admissions review.

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. The lead GP told us that due to the location of the practice many patients from different backgrounds were registered at the practice and they ensured all patients' needs were met appropriately. We saw a 'non-discriminatory practice statement' statement displayed on one of the notice boards in the practice waiting area. This informed patients that the practice would not discriminate on the basis of race, colour, gender, age or national origin. Staff were supported with training in equality and diversity.

Minor surgery was regularly undertaken at the practice by one of the GPs. The practice had looked at recognised complications of minor surgery such as excessive bleeding and infection rates. However they acknowledged that these did not amount to fully verifiable audits and none were available to view at the time of the inspection. The GP doing minor surgery had been appropriately updated in the last three years.

Management, monitoring and improving outcomes for people

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. Staff members we spoke with confirmed that the practice was supportive and proactive in providing training. For example, the new nurse was being supported to attend courses as they had returned to the role after an absence. The nurse was positive about the support received from a GP partner and other staff.

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).

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the Quality and Outcomes Framework **(**QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. For example, 39% of patients with chronic obstructive pulmonary disease (COPD) and 59% of patients with asthma had received an annual review so far this year. (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema) Previous data we looked at showed that the practice results were in line with the local and national target. Records of meetings we looked at showed that QOF targets were discussed. The GPs were, at the time of our inspection, undertaking most of the reviews as the practice did not have a nurse from February 2014 to October 2014. The new nurse was undertaking courses in Spirometry (a test used for lung conditions such as asthma) and diabetes. Once the nurse had finished their training they would be taking on more responsibilities in regards to QOF reviews.

The practice had a palliative (end of life) care register and had regular contact with multidisciplinary teams and attended relevant meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff had attended training courses that were relevant to their roles. Staff members we spoke with confirmed that the practice was supportive and proactive in providing training. For example, the new nurse was being supported to attend courses to increase their level of expertise.. The nurse was positive about the support received from a GP partner and other staff.

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).

The practice had recruited three new reception staff that were not due an appraisal. However, one of the reception staff had worked at the practice for some time and records showed that they had undergone an appraisal.

Working with colleagues and other services

Discussions with staff and records showed that the practice worked in partnership with other health and social care providers such as social services, end of life care teams and district nursing services to meet patients' needs.

The practice participated in multidisciplinary team meetings as required to discuss patients with complex needs, for example those with end of life care needs or children who were considered to be at risk of harm. These meetings included district nurses and community matrons. Decisions about care planning were documented in each patient's record.

Emergency hospital admission rates for the practice were relatively similar compared to the local and national averages. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. We saw that the policy for actioning hospital communications was working well in this respect. There was an 'on call' GP who would be responsible for actioning for example results from hospitals. Records we looked at showed that they were actioned within 48 hours. Locum GPs were not included in the 'on call' system.

Information sharing

The practice had a system where referrals by GPs to other providers such as hospitals (except urgent referrals) were peer reviewed. Records we looked at showed that all locum referrals we reviewed and were actioned quickly. This helped to improve the quality of referrals. Relevant patients we spoke with confirmed that the referral process was quick and staff went through the process with them.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. Staff were fully trained on the system and new staff were being trained. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that communication from hospital was actioned within 48 hours by an 'on call' GP.

Good

Are services effective?

(for example, treatment is effective)

We also saw evidence that the practice sent fax to out-of-hours providers for patients on the palliative care register.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Electronic systems were also in place for making referrals and the practice managed referrals through 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).

The GP and practice nurse we spoke with told us they had good working relationships with community services, such as district nurses. We saw evidence of good evidence of joint working relationships through multidisciplinary meetings.

Consent to care and treatment

The practice had a process to ask for, record and review consent decisions that were needed from patients. We saw there were consent forms for patients to sign agreeing to minor surgery procedures.

We found that staff were aware of the Mental Capacity Act (MCA) 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. We saw that the staff had attended training on MCA two days before our inspection visit.

The GPs we spoke with demonstrated a clear understanding of the Gillick competencies. The Gillick competencies help clinicians to identify children under 16 years of age who have the legal capacity to consent to medical examination and treatment

Patients told us they had been involved in decisions about their healthcare and treatments. They had been provided with sufficient information that enabled them to make choices and felt they had been able to ask questions when they had been unsure about anything.

Health promotion and prevention

Latest data we looked at showed that the practice performance in relation to health promotion activities such as cervical screening, diabetes checks, cardiovascular disease prevention as well as child health surveillance was in line with local and national rates.

The practice had a wide range of health promotion leaflets and self-help guides in the surgery and on their website. The practice offered health checks to those patients aged between 40 - 74 years. These were led by the healthcare assistant (HCA) and enabled the practice to identify any early indications of disease or health problems.

The practice also had five well laid out health promotion notice boards in the main waiting area as well as in the second waiting area informing patients of other services such as mental health and sexual health that was available to them. The notice boards were generally specific to patient groups. For example, there was a notice board with information for carers, another with information on heart disease, lung conditions and diabetes. There were display screens which also provided various health promotion advices such as increasing physical activity. Health promotion leaflets were also available in the waiting area.

The practice was proactive in promoting health and health screening services. Data provided to us showed that the practice had carried out 70% of cervical smears for the eligible patients so far this year. We saw 89% of patients had cessation advice as well as 87% of patients over 45 had their blood pressure checked.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The lead GP explained that due to their location many patients registered with them travelled frequently and to multiple locations. They told us and we confirmed that the practice was a yellow fever approved centre. Last year's performance was similar to local CCG average for majority of immunisations where comparative data was available. For example childhood immunisation rates for the vaccinations given to under twos ranged from 91% to 92% These were comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 33 completed cards and the majority (27) 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, were fantastic and met their needs. We also spoke with four patients including the chair of the PPG. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We reviewed the most recent data available for the practice on patient satisfaction from the national GP Patient Survey dated January 2015. The evidence showed that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data showed that 93% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%. Eighty five percent of the patients returning the survey also said that the GP gave them enough time compared to the CCG average of 82% and national average of 86%. Data for nurses were generally higher than local and national averages in this area.

The practice also had a patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG helped to undertake a patient survey in March 2014. Patient satisfaction questionnaires were also sent out to patients by each of the practice's partners. Results showed that patients were overall satisfied with the service.

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. The practice switchboard was located in a separate room behind the reception area desk which helped keep patient information private. A system had been introduced to allow only one patient at a time to approach the reception desk and we saw notices in the reception desk asking patients to keep back away from the reception desk if it was not their turn. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Care planning and involvement in decisions about care and treatment

The national GP 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, 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%. Eighty four percent of patient in the survey said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and national average of 82%. The results were also similar for the nurse.

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.

Patient/carer support to cope emotionally with care and treatment

The patient 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 91% of respondents said the last GP they saw or spoke to was good at treating them with care and concern; this was above the local CCG and national average which were 80% and 85% respectively.

Good

Are services caring?

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, one comment card stated how all staff respected and cared about them.

Notices in the patient waiting room, on the TV screen and notice boards in the practice as well as the patient website told patients how to access a number of support groups and organisations. For example, the website alerted patients to an alcohol service, drug service, social services as well as pregnancy advice service.

Staff told us that if families had suffered bereavement a message was sent to all staff and a card was given to relatives giving them advice on how to find a support service. This was followed by a call to the relatives and their records noted of the bereavement so flexible appointment including longer appointments could be offered.

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. One of the GP partners explained that they were a designated practice for substance misuse and had a drug worker attached to the practice. The practice was also a yellow fever approved centre. This was useful for those patients who travelled frequently.

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) survey. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, it was recognised that access was an issue and the practice had recruited a part time GP to work five sessions per week, this included early morning start at 7.30am on Tuesdays and late evening on Thursdays to finish at 7.30pm. This also helped to accommodate working patients. Telephone access was also highlighted as an issue. Staff members we spoke with told us that there had been a shortage of reception and administration staff previously. The practice had recruited three new staff to ensure that phone calls were answered and dealt with in a timely manner as well as being able to process patient queries, prescription requests, booking appointments more efficiently.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. Staff members we spoke with told us that there were many asylum seekers registered at the practice. Staff told us that they tried to find out what language the patients spoke before registering with the practice so that an appropriate translator could be booked for them. Staff also told us that on occasions they used an internet translation service to communicate with patients who did not speak English as a first language.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access to toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Car parking was available to patients and there was a marked bay for people with physical disabilities and a disabled accessible entrance just next to this bay. Staff showed us the CCTV and buzzer system where patients using a wheel chair could use to ask for assistance from staff to enter the building.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. The practice had added the GP session including the female GP partners on their website so that patients were aware. This included extended evening hours so that patients' needs to see a female GP after working hours could be accommodated.

Access to the service

The surgery was open from 8.30am to 6pm Monday to Friday except on Wednesday when it closed 12.30pm with alternative cover arrangements in place. Extended hours were available from 7.30am with a GP on Tuesdays. Extended late opening was available until 7.30pm on Thursdays. The practice also opened on a Saturday morning anytime the practice was closed for four days due to bank holidays.

The appointment system had been changed recently which meant that advanced appointments with the GPs were routinely offered two months in advance for the afternoon only. Limited advance appointment was available in the morning. This enabled more appointments to be booked on the day as the practice had identified, from patient feedback, access was an issue.

Information was available to patients about appointments on the practice website. This included how to register as a patient at the practice, how to arrange appointments and if someone else could join patients during consultations. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were available to those who were unable to attend the practice. Staff told us that they did not generally receive many requests and we did not see this service widely advertised in the practice or the website.

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 a complaints and comments leaflet was available to help patients understand the complaints system. The leaflet also had a complain form for patients to use. Not all patients we spoke with were aware of the process to follow if they wished to make a complaint. However, none of the patients we spoke with had ever needed to make a complaint about the practice.

We saw that there was one complaint that was received through NHS England this year and the practice had responded to the complaint. We saw that the practice had received five complaints in 2014. We looked through some of the complaints and saw that they were responded to appropriately according to the practice complaints policy and procedures.

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. We found details of the vision and practice values were part of the practice's 2015/16 business strategy. The business strategy was to grow the practice to a four partner GP site and increase patient numbers from 6800 to 8000. It was hoped that this would help to fully utilise the building where the practice was located. Staff members we spoke with were aware of this vison. The practice manager told us that they had lost some patients when they had moved to their current site four years previously. They told us that they had since increased their list size from 3800 to 6800 and expected this to grow further.

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. The practice manager told us that with the previous shortage of staff they had found it difficult to maintain all administrative duties as they often helped out in the reception. However, with the recruitment of more reception staff they were currently updating all the policies and making them available to all staff electronically. The practice nurse we spoke with told us that they were recently given access to policies electronically on their computer. The practice manger told us that they had updated and reviewed 80% of the practice policies over the last few months. Previously, staff had access to policies through their handbooks given to them when they started.

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 the senior partner was the lead for safeguarding. We spoke with four 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. For example, the practice nurse was being supported to attend courses to enhance their skills.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was a standing agenda in the monthly practice meetings.

The practice also 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, the practice sent us a summary of some of the audits that were carried out before the inspection with actions they had taken. During the inspection we looked at an audit and saw that appropriate action identified in the audit had been taken. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. For example, the practice responded to findings from patient the survey by increasing the number of appointments available and making more appointments available on the day.

Leadership, openness and transparency

We saw that practice staff held a range of regular meetings. They included practice meetings, clinical meetings as well as with multidisciplinary teams. The minutes of some of the meetings we looked at showed that all aspects of the running of the practice were discussed as well as ways of taking corrective actions to meet patient's needs.

Staff described management as being very open and honest. During our inspection we found the lead GP and practice management to be open about the challenges the practice had regarding staffing over the last 12 to18 months. A staff member we spoke with told us they were supported by a GP partner and the practice manager.

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

The practice had an established Patient Participation Group (PPG) in place. PPGs are group of patients registered with a practice who work with the practice to improve services and the quality of care. Minutes of meetings we looked at showed that the PPG met regularly. We spoke with the chair of the PPG who confirmed this. The PPG

Are services well-led?

Good

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

chair confirmed that the practice listened to the PPG and actioned suggestions where appropriate. For example, the appointment system had been changed to allow effective access to patients. The PPG chair explained that morning appointments were kept for on the day requests apart from the first two which were pre-bookable. Staff members we spoke with told us that this had made a difference to access and the PPG chair told us that this was being piloted and would be reviewed by the PPG and the practice.

The practice had also gathered feedback from patient surveys. Most of the findings related to access and we saw evidence that the practice was responding to them. For example, the practice was offering late and early appointments for patients who were unable to attend during normal working hours. The PPG chair also told us that the practice had trialled opening on alternate Saturdays but that had not been very successful due to low uptake.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice nurse we spoke with was being supported with training in diabetes. Most of the staff had been recruited recently and were not due an appraisal. However, we did see evidence of appraisal that had taken place within the last 12 months for staff who had been working at the practice for longer.

The practice was a GP training practice and there was a trainee working at the time of our inspection. We spoke with the trainee who told us that they felt supported. Both of the GP partners were trainers.