Forty Willows Surgery

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 an announced comprehensive inspection at Forty Willows Surgery on 21 October 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; people of working age; people whose circumstances may make them vulnerable and people experiencing poor mental health.

Our key findings were as follows:

- The practice had effective systems in place to manage risks associated with medicines management, staff recruitment, infection control, child protection and medical emergencies.
- The practice understood the needs of the population and had developed the service and skills of the staff team to meet patients' needs. We found that care for long-term conditions such as mental health and diabetes was being managed effectively in the community and was provided in partnership with other specialist services.
- Patient satisfaction scores were better than local averages for quality of care and in line with local averages for access to appointments. Twenty-five patients completed Care Quality Commission (CQC) comment cards about the service before our inspection. All of these were positive about the service and staff.
- The practice was a training practice, providing placements for trainee GPs. We found that both the trainees and staff were well supported. Staff told us the practice was clinically and managerially well-led with opportunities to reflect on practice and improve.

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

Importantly the provider must

- Ensure that its website provides patients with accurate information about how to access primary care services when the practice is closed.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Reviews and investigations were thorough and lessons learned were communicated to support improvement. Risks to patients who used services were assessed and the practice had systems and processes to address risks in relation to infection control, medicines management and dealing with emergencies. The practice carried out appropriate checks when recruiting new members of staff to ensure they were suitable to work in general practice. All staff had been trained on safeguarding vulnerable adults and child protection and staff who undertook chaperone duties were clear about how to carry out this role effectively.

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 NICE and used it routinely. People'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 planned. The practice staff received annual appraisals including personal development planning. Staff communicated and worked with other services when appropriate and the practice held multi-disciplinary meetings and case reviews for patients with complex and palliative care needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly for the quality of its 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. The practice reviewed the needs of its local population to secure service improvements where these had been identified. The practice acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation

group. For example, reorganising the appointments system to enable better telephone response and access to same-day emergency appointments. The practice provided information for patients on how to access primary care services when the practice was closed in its practice leaflet and via a recorded message on its telephone line. However the practice website included out-of-date information about this.

Patients told us they could get an appointment when they needed one. The practice also scored well on access to appointments in the 2014 National GP Patient Survey. Information about how to complain was available and easy to understand, and the practice responded promptly when issues were raised. Learning from complaints and feedback was shared 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 and supported the GP partners to lead effectively. This was reflected in day to day practice and engagement with commissioners and providers. 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. Staff had received inductions, regular performance reviews and attended staff meetings.

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 health 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 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 complex needs. All patients over 75 had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. Patients with complex long term conditions had a named GP and a structured annual review to check that their health needs were being met and review treatment and medicines. 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. The practice ran clinics for common long-term conditions, for example, to support patients with diabetes which included a focus on self-management and maintaining good long term health.

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 who were at risk, for example, with a high number of A&E attendances. The practice ran regular safeguarding meetings with health visitors and social care professionals to ensure that concerns were followed-up and referred appropriately.

Immunisation rates were relatively high for standard childhood immunisations at 24 months and five years. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

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 practice had

Summary of findings

adjusted the services it offered to ensure these were accessible and flexible for people of working age. The practice was proactive in offering online services as well as a full range of health promotion and screening, reflecting the needs of 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 maintained a register of people with learning disabilities. People with learning disability received an annual health check. The practice provided joint consultations and assessments with the community learning disabilities nurse to ensure that patients' wider needs were addressed. The practice offered longer appointments for people with a learning disability or other complex needs.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff were aware of the needs of particular groups for example, the practice provided care to travellers when they were in the area. 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.

The practice kept a register of carers and encouraged carers to be involved in patient reviews. Information for carers was displayed in the waiting area. Staff were aware that carers were at increased risk of mental and emotional stress and physical health problems.

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. The practice provided primary care to a number of patients with severe and enduring mental health problems and/or alcohol and substance misuse problems. The practice had a dedicated GP who looked after these patients on a regular basis and regularly reviewed both their mental and physical health.

Summary of findings

What people who use the service say

The 2014 National GP Patient Survey results showed that patients were generally positive about the quality of care they received. The practice was performing in line with local area and national averages on a range of scores relating to quality of consultations with doctors and how well patients were involved in decisions about their care. The practice scored better than the local and national averages for questions on whether patients would recommend the service to others and how easy it was to access the service.

We spoke with three patients who used the service and received 25 Care Quality Commission (CQC) comment cards with feedback from patients. The feedback was wholly positive about the practice with patients saying that the staff were caring, understanding and involved patients in treatment choices. We spoke with one patient who used the practice regularly who told us they received very good ongoing care and support from the nurse practitioner. The practice engaged patients through a patient participation group and conducted its own annual survey.

Areas for improvement

Action the service MUST take to improve

The practice must ensure that its website provides patients with accurate information about how to access primary care services when the practice is closed.

Forty Willows Surgery

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 who was granted the same authority to enter the practice premises as the CQC inspector.

Background to Forty Willows Surgery

Forty Willows Surgery is located in Wembley in North West London. The practice provides NHS primary medical services through a General Medical Services contract to 6,600 patients in the local community. The practice has a larger than average proportion of adults in the 25-39 age range and babies and is ethnically diverse. Income deprivation levels for the practice population are somewhat higher than the English average.

The current practice staff team includes three GP partners, two nurses one of whom is a nurse practitioner (that is a practice nurse who has qualified to take on additional responsibilities and can prescribe medicines), an interim practice manager and a team of reception and administrative staff. The practice is an NHS GP training practice and a number of GP trainees (registrars) also work and train in the practice at any one time. Both male and female doctors are available.

The practice is open weekdays from 09:00 until 18:30 with extended hours on Tuesday evening until 20:00 and Wednesday morning from 08.10. The practice closes for an hour at lunchtime and is also closed on Wednesday afternoon for staff training and meetings. The practice has opted out of providing out-of-hours care and sign-posts patients to local out-of-hours primary care and emergency services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This provider had not been inspected before and that was why we included them.

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 the Clinical Commissioning Group, NHS England and the local Healthwatch to share what they knew. We carried out an announced visit on 21 October 2014. During our visit we spoke with a range of staff including four GP partners, a sessional GP, a GP trainee, a practice nurse, the practice manager, a health care assistant and three administrative staff. We reviewed fifteen patient records. We spoke with three patients who used the service. The practice also displayed a notice about the inspection in the waiting area and feedback forms for patients to complete in the days preceding the inspection. We reviewed 25 completed Care Quality Commission (CQC) comment cards.

Good

Are services safe?

Our findings

Safe track record

The practice analysed and monitored information to identify risks and improve patient safety. It had systems to monitor reported incidents, national patient safety alerts, and complaints received from patients. For example the practice staff had discussed a recent national alert about the Ebola virus and as a result displayed information for patients on what to do if they were at risk and feeling unwell. The staff and trainees we spoke with were aware of their responsibility to raise concerns, and knew how to report incidents and near misses. The practice had kept a register of significant events for a number of years and showed us a summary of events from the previous twelve months. The trainees were aware of the significant events register and how to access this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and we reviewed these for the previous year. Significant events were discussed at the weekly clinical team meeting and a dedicated meeting was arranged to review the causes, learning and actions when events occurred. The most recent event had occurred in May 2014 and this had been fully documented and a meeting had been held. There was evidence that the practice learned from events and that the findings were shared with relevant staff and other agencies when appropriate.

Staff including receptionists, GP trainees, nursing staff and health care assistants knew how to raise an issue for discussion at the meetings and they said they were encouraged to do so. For example, the trainee we spoke with had used the meeting to discuss a complaint from a patient about an entry in their patient notes. This had been referred for legal advice and the response shared with the other clinical staff.

The practice stored a record of all incidents in an electronic register. For example, an incident had occurred when a patient who was taking an anticoagulant medicine was prescribed another medicine and suffered adverse effects. The practice reviewed the incident and amended the relevant prescribing procedure for patients to include a double check that any additional prescription or change of dose was appropriate and safe. The doctors we spoke with were aware of the importance of monitoring patients on medicines such as warfarin, ensuring the patient's "yellow book" was up to date and the changes to the prescribing policy. We asked several members of staff about the incident during the inspection and they consistently explained what had happened and the learning points.

National patient safety alerts were disseminated electronically to practice staff. Staff we spoke with were able to give examples of recent alerts, for example on consistently screening patients presenting with infection for sepsis, that were relevant to the care they were responsible for. They also told us alerts and guidelines were discussed in the regular clinical team meeting to ensure all clinical staff were aware of any that were relevant to the practice and where they needed to take action.

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 child protection. The qualified GPs had been trained to Level 3 in child protection. The nurses and the GP trainees had completed Level 2 training with the trainees scheduled for Level 3 training before qualifying. Administrative staff members were trained to Level 1. Staff had also received training on recognising abuse in vulnerable adults. Staff members understood their responsibilities to share information, properly document safeguarding concerns and how to contact the relevant agencies both in and out of working hours.

The practice routinely reviewed safeguarding cases covering both children and vulnerable adults and involved other professionals and agencies as appropriate. The practice staff were able to give us recent examples of safeguarding cases in which they had been involved, for example, a trainee doctor had raised concerns about a patient with children who was experiencing acute mental health problems. As a result the patient had been referred to specialist health services and social services were supporting the family. Another recent example involved the suspected sexual abuse of a child which the police were investigating and other relevant agencies were aware.

Good

Are services safe?

The practice had a dedicated lead GP for safeguarding vulnerable adults and children. All the staff we spoke with were aware of who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. The practice nurse and health care assistants had been trained to be chaperones and were clear about the purpose of chaperoning and how to carry this out. These staff members had undergone Disclosure and Barring Service criminal records checks.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There were systems in place to identify and follow-up children with multiple attendances to A&E.

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice followed set procedures to ensure that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data and significant events involving medicines. For example, following an incident involving an overdose, the practice had reviewed its repeat prescribing policy to ensure that certain medicines were no longer available on repeat prescription. 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 and stored securely.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance.

There was a system in place for the management of high risk medicines, which included regular monitoring and auditing to check these were prescribed in line with national guidance.

Cleanliness and infection control

The premises were clean and tidy. Patients told us they had no concerns about cleanliness or infection control. The practice contracted with a cleaning company with set cleaning schedules and records of monthly, weekly and daily tasks. Cleaning was carried out in line with current national guidance, for example in relation to cleaning materials and equipment.

The practice nurse was the lead for infection prevention and control with the support of one of the GP partners who had oversight of infection control monitoring and reviewed the infection control audits. All staff received training about infection control specific to their role and received annual updates. We saw evidence that the practice carried out regular infection control audits and had implemented recommendations made following the most recent external audit of infection control carried out by NHS England.

The practice had an infection control policy. This was comprehensive and covered for example, the disposal of sharps and the management of instruments, biological substances, waste management and hand washing. There was also a protocol for needle stick injury. The practice used single-use equipment wherever appropriate, for example only using single-use tips for minor surgery.

Personal protective equipment including disposable gloves was available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in treatment rooms and the staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were also provided in the treatment rooms. The

treatment room used for minor surgery was appropriately equipped with a designated clean area. The layout of this room had been organised to minimise the risk of cross-contamination.

A risk assessment for Legionella (a bacterium that can grow in contaminated water and can be potentially fatal) had been carried out and improvement works to the water tanks had been carried out as recommended in the assessment.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that equipment was tested and maintained regularly in line with the manufacturers' instructions and we saw equipment maintenance logs and other records confirming this. For example the nebulisers and weighing scales were checked annually. The weighing scales had been found to be faulty during the check in 2012 and had been immediately replaced. We saw evidence that relevant equipment such as spirometers and blood pressure monitors were calibrated annually (that is, checked to ensure that they gave readings that were accurate and reliable).

Staffing and recruitment

Records we looked at included evidence that all appropriate recruitment checks had been undertaken prior to employment. The practice had checked staff members' qualifications, references, registration with the appropriate professional body, and had undertaken criminal records checks through the Disclosure and Barring Service for all staff members.

Staff told us about the arrangements for planning and monitoring the number and mix of staff required to meet patients' needs. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice arranged temporary locum cover if staffing levels became low or patient demand increased.

Staff told us there were enough staff to maintain the smooth running of the practice and to keep patients safe. The practice manager monitored day to day staffing levels in relation to clinical need. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. The senior GP partner told us that persistent staffing issues would trigger a review within the practice.

The practice currently did not have a permanent practice manager or a health care assistant. The partners had secured the services of an experienced interim practice manager while they recruited a suitable person for the longer term. The practice was undertaking an assessment of its existing nursing and health care assistant skills and patient needs before recruiting further members of the practice team.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety lead and policy. Health and safety information was displayed and visible to staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and interviews showed that all staff had received training in basic life support within the last two years and knew how to respond to an emergency. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they knew the location of this equipment and records confirmed that it was checked regularly.

The practice kept a small stock of medicines for use in an emergency. These included medicines for the treatment of cardiac emergencies, anaphylaxis and hypoglycaemia. The practice nurses were responsible for checking whether emergency medicines were within their expiry date and suitable for use and we saw records showing these checks were completed. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that might affect the daily operation of the practice. Each risk was rated and mitigating actions

Good

Are services safe?

recorded to reduce and manage the risk. Risks identified included power failure, failure of computer systems, adverse weather, unplanned sickness, and access to the building.

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

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. The GPs met regularly with the local prescribing advisors and used this as an opportunity to review any updated prescribing guidelines.

We saw minutes of practice meetings where particular topics and guidelines were discussed and shared. For example a recent clinical meeting had focused on antibiotic prescribing guidelines and one of the GPs had produced an updated summary of "first line" antibiotics for various infection types, alternatives if patients were allergic to penicillin and medicines suitable for children.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs and reviewed care and treatment when appropriate, for example, if a patient's condition was not improving as expected.

Individual GPs led in specialist clinical areas such as diabetes, family planning and mental health, and the practice nurses supported this work. The practice ran a number of specialist clinics covering long-term conditions such as diabetes. The GP and practice nurse team had developed special clinical interests which were linked to the needs of the local population. For example, the practice nurse was planning to attend a course to extend her knowledge of asthma, the prevalence of which was high amongst children in the practice population. Following review, the practice was considering stopping a service to provide contraceptive implants as uptake was very low. The practice had appointed clinical leads for various long term conditions such as diabetes, care planning, safeguarding and infection control.

The practice manager showed us the practice's Quality and Outcomes Framework (QOF) results and data collated by the Clinical Commissioning Group of the practice's relative performance on a range of measures (such as practice immunisation rates). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice performance was generally better than similar practices in a number of areas with an overall QOF score of 97% for the previous year. The practice's referral rates to secondary services were in line with other practices in the Clinical Commissioning Group area. The practice had systems in place to ensure that GPs were able to meet national standards, for example, for the referral of patients with suspected cancers who were referred within two weeks.

The practice had a palliative care register and held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families towards the end of life or who had particularly complex health conditions. The practice produced care plans for patients with complex or challenging needs.

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 was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff and the practice as a whole.

We did not see an annual audit plan for the practice but the GPs described a number of recent clinical audits and completed audit cycles to check that their practice was in line with recognised standards and to identify areas for improvement. There was a clear rationale for each audit we reviewed and the results and learning were discussed at the weekly clinical meetings. For example, the practice had completed an audit of atrial fibrillation, repeating the audit after twelve months to ensure that improvements had been made and sustained. As a result of this work, the practice was diagnosing the condition more consistently and more patients were being treated with anti-coagulant medicines to reduce their risk of stroke.

The practice participated in local benchmarking exercises run by the Clinical Commissioning Group (CCG). This is a

Good

Are services effective?

(for example, treatment is effective)

process of evaluating performance data from the practice and comparing it to other similar practices in the area. This benchmarking data showed the practice had outcomes that were generally comparable to other practices. The practice followed up any unexplained variation identified through benchmarking with more detailed clinical review and audit. Clinical audits and data collection exercises were also undertaken as part of the practice participation in the QOF and other contractual requirements.

The doctors and nurses had opportunities to reflect on the quality of the service. The formal mechanism for this was primarily through a weekly clinical meeting but staff also had the opportunity to meet informally each day during the lunch break. The wider staff team met monthly. Community nurses and health visitors were invited to alternate meetings for case reviews in relation to care planning, palliative care and safeguarding.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with mandatory courses such as annual basic life support. The practice manager monitored attendance. The GPs were up to date with their yearly continuing professional development requirements and had either 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 wider staff team also received annual appraisals. The appraisal documentation included consideration of learning needs, and any learning plans and agreed actions were signed by both the appraiser and staff member being appraised. We saw examples of staff members identifying clinical training needs, for example on wound management which were supported. Interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The practice was a training practice, that is, doctors who were training to specialise as GPs undertook a working placement at the practice under supervision. The practice was hosting two GP trainees (registrars) at the time of the inspection. The registrars had extended appointments with patients and had access to a senior GP throughout the day for support. We spoke with two registrars who were enthusiastic about the practice and the support they were receiving.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were appropriately trained and supported to fulfil these duties, for example, on cervical cytology. The nurse practitioner had appropriate training, the ongoing support of their GP colleagues and was confident they were acting within their competencies.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. The practice communicated with out-of-hours services electronically and was made aware the next morning of any patients who had required care out-of-hours who might need following up. The clinical staff told us they were able to contact specialist consultants from a range of specialties for advice on the management of specific cases. We spoke with one patient who told us they had complex health needs and the practice had effectively co-ordinated their care with a number of other health and social care agencies.

The practice held multidisciplinary team meetings for example, to discuss the needs of complex patients and those with end of life care needs. These meetings were attended by district nurses, palliative care nurses, and a geriatrician and decisions were documented in patients' individual care plans. Patients were supported to make an 'advance directive' if they wanted, setting out their wishes for their care at the end of their life. This was recorded with the patient's electronic notes so that health care staff had access to this information when it was required.

The practice had a number of patients with substance misuse problems and worked with local substance misuse services to provide safe and appropriate drug replacement therapy to these patients. For example, one patient did not like the liquid form of methadone which is recommended for prescription in general practice. The practice referred this patient to the local substance misuse specialist service so they could receive their prescription in tablet form with appropriate monitoring.

The practice maintained a register of people with learning disabilities. One of the GPs took the lead for learning disabilities to provide continuity of care. People with

Good

Are services effective?

(for example, treatment is effective)

learning disability received an annual health check. The practice provided joint consultations and assessments with the community learning disabilities nurse to ensure that patients' wider needs were addressed.

Information sharing

The practice communicated with other providers electronically. Electronic systems were in place for making referrals, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. The practice had recently changed to a different electronic patient record to coordinate, document and manage patients' care. All staff had received training on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that a risk assessment had been carried out to ensure that the move to the new system did not compromise or result in the loss of patient information.

The practice had a written protocol covering the handling of results, post and other communications to ensure these were acted on promptly. This had been produced following an incident when several reports were delayed. Staff we spoke with understood these procedures and their responsibility. All incoming letters and results were forwarded to the appropriate member of staff or, if they were unavailable, to the duty doctor for review.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and children's Acts 1989 and 2004 and their duties in relation to this legislation. 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 and help develop a care plan. Care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. Carers were also encouraged to be part of the care planning process. Clinical staff understood the Gillick competencies and recorded consent obtained in these circumstances in the patient notes. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

The practice had a policy on obtaining consent for specific interventions. For example, we saw that patients' consent to minor surgery was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice partners were aware of the needs of the practice population and how population needs were changing. This information was used to help focus health promotion activity and encourage patients with poor access to services to register with the practice.

New patients were offered health checks with a practice nurse. Any concerns were referred to a GP for follow up. GPs used their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and checking how new mothers were feeling emotionally at the six-week postpartum check. The practice offered NHS health checks to patients aged 40-75 to advise patients about their lifestyle risk factors and symptoms before these developed into more serious health conditions. The practice kept a register of all patients with a learning disability who were offered an annual physical health check and this included advice on managing any health problems and how to keep well.

The practice identified patients who needed additional support, and it was pro-active in offering additional help. The practice offered condition-specific clinics and reviews for example for diabetes, asthma and heart disease prevention to promote health; provide advice, and to support people to manage their own conditions.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations at 24 months and five years was above average for practices in the CCG, with a clear policy for following up non-attenders. For example 95% of eligible five year olds in the practice completed their MMR vaccinations. Ninety-seven per cent of patients with diabetes had received the annual flu vaccination. All patients over 75 had a named GP.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National GP Patient Survey. The evidence from these sources showed patients were satisfied with how they were treated. For example, data from the national GP patient survey showed that 78% of practice respondents would recommend the practice compared to the Clinical Commissioning Group (CCG) average of 70%. The practice performed in line with the CCG and England averages for its satisfaction scores on consultations with doctors with 81% of practice respondents saying the GP was "good" or "very good" at treating them with care and concern and 99% saying they had confidence and trust in the last doctor they saw at the practice.

Twenty-five patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. These were all positive about the service experienced. Patients described the service as excellent and the staff as helpful, understanding and friendly. We also spoke with three patients on the day of our inspection. All told us they were happy with the care provided by the practice and said their dignity and privacy were respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy 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.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that personal information was kept private. The practice waiting area was located in a separate area to the reception desk.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and generally rated the practice well in these areas. For example, data from the national patient survey showed 80% of practice respondents said the GP involved them in care decisions which was in line with the CCG and England scores. Eighty-four per cent reported the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed that patients were positive about the quality of care they received from doctors, nurses, health care assistants and the reception team. For example, 82% of respondents reported being satisfied with their last visit to the practice.

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.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The website included information in a range of languages about how to book an interpreter.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with and the feedback forms we received described the staff as understanding and compassionate. Notices in the patient waiting room and patient website informed patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. Staff told us that if families had suffered bereavement, they were contacted and referred to counselling and bereavement services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood within the context of the broader commissioning priorities for the borough and the socio-demographic profile of the population. The GP partners engaged with other GP practices, local commissioners and other organisations to provide and maintain a service that met patients' needs, for example contracting with a local nursing home to provide the people living there with responsive primary medical care.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the practice patient participation group. For example, the reference group had identified the appointment booking system and the telephone charges as issues. As a result, the practice had changed the telephone system to a cheaper, local charging rate and had extended appointment times.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Services for patients were located on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for reasonably easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice could cater for different languages through translation services.

Access to the service

The practice was open weekdays from 09:00 until 18:30 with extended hours on Tuesday evening until 20:00 and Wednesday morning from 08.10. The practice closed for an hour at lunchtime and was also closed on Wednesday afternoon for staff training and meetings. When the practice was closed, patients were directed to the out-of-hours service. The practice posted information about this at the surgery and with a telephone message. However, the practice website contained out-of-date information about the out-of-hours service.

Comprehensive information about appointments was available to patients on the practice website and in the practice leaflet. This included information on opening times, 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, their call was put through to the out-of-hours service. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The nurse practitioner led on reviewing the care of patients with diabetes and was undertaking further training on initiating insulin for eligible patients.

Although the practice's own survey identified access to appointments as an issue for patients, the practice scored highly in the 2014 National GP Patient Survey on some aspects of access. Seventy-five per cent of patients reported their experience of making an appointment as good compared to the Clinical Commissioning Group (CCG) area average of 68%. The practice offered bookable appointments and emergency consultations the same or next day with a duty doctor. Most of the patients we spoke with during the inspection thought this system worked well.

The practice ensured all known individuals with complex or more challenging needs were allocated to a named doctor. The practice added alerts to the electronic records system to inform reception staff that certain patients usually required longer appointments.

Listening and learning from concerns and complaints

The practice had a complaints policy and procedure. The practice manager was the lead for complaints in the practice. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available in the practice leaflet to help patients understand the complaints system. This was displayed in the waiting area and on the practice website. Some but not all 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 needed to make a complaint about the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at six complaints received in the last 12 months and found these had been handled in line with the practice policy. We saw that complaints were taken seriously and investigated in a timely way and were analysed for patterns. Where complaints were upheld the practice apologised and informed the complainant of actions taken to reduce reoccurrence. We saw one example where a patient was invited to the practice so the doctor could explain what had happened and how the practice would learn from the error. Complaints were used as a source of learning and actions shared with the staff team, for example. Staff described the culture within the practice as supportive and said their experience of sharing complaints with colleagues was handled constructively.

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; promote good outcomes for patients; provide an effective training environment for GP registrars and to work effectively with other services. The vision and practice values were used to focus the practice's strategy and business planning, for example, the need to employ a high calibre practice manager. The practice displayed its mission statement on the website and in the practice leaflet. Not all members of staff could describe the practice mission statement with confidence but they were able to articulate the aims of the practice in general terms and knew what their responsibilities were.

Governance arrangements

The practice had developed policies and procedures to govern activity and these were available to staff on the desktop on any computer within the practice and paper copies were also available in the practice manager's office. The policies we saw had been reviewed within the last twelve months. The members of staff we spoke with were clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was achieving well, including against measures of how well organised they were, for example, on record keeping and obtaining patient feedback. Progress against the QOF and other contractual targets was monitored by the practice manager and the partners.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. There were designated leads for specific areas of risk, for example, there was a lead nurse for infection control and named clinical leads for safeguarding.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. The GP partners we met spoke positively about taking advantage of available opportunities to develop primary and integrated services for their patients.

The practice partners were also reviewing how to develop the skills of the whole practice team, in particular the health care assistant roles to better meet local needs.

We saw from minutes that full team meetings were held monthly since the temporary practice manager had started in the role. Staff told us that there was an open culture within the practice and they had the opportunity and were increasingly happy to raise issues at team meetings. We also noted that there had been a recent social event for all staff.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment procedures, induction policy, and management of sickness which were in place to support staff. The policies we reviewed had been updated within the last year and were reviewed annually. 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

The practice gathered feedback from patients through national patient survey results, its own annual patient survey, reviews on the internet, comment cards and complaints. We looked at the results of the practice's 2014 patient survey. The main issue raised was the length of time it took patients to book an appointment. The practice had agreed an action plan with the patient participation group to address this.

The practice had reviewed the composition of the patient participation group to see if it was representative in terms of ethnic diversity, sex and age. The practice manager had identified a need to recruit younger patients to the group, and was in the process of planning how to achieve this.

The practice gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they were comfortable giving feedback and could discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Are services well-led?

Good

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

Management lead through learning and improvement

Education and training was a strategic priority for the practice and this was reflected in practice. Two of the GP partners were accredited GP trainers and the practice hosted GP trainee registrars from a recognised university postgraduate training programme. The GP trainees spoke highly of the quality of training and support they received which included protected time for discussion, presentation and reflection with established clinical staff members.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We were consistently told that the practice encouraged staff development in order to improve services for patients and saw evidence of this in appraisal documentation.

The practice management disseminated learning across the staff team. For example, we asked staff about specific significant incidents that had occurred within the previous twelve months. Staff members could recall the events in question and the key learning points for their day to day practice.