Eastmead Avenue Surgery

Quality Report

20 Eastmead Avenue, Greenford, Middlesex, UB6 9RB
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Date of inspection visit: 8 January 2015
Date of publication: 05/03/2015

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 Eastmead Avenue Surgery on 08 January 2015. We rated the practice as 'Good' for the service being safe, effective, caring, responsive to people's needs and well-led. We rated the practice as 'Good' for the care provided to older people and people with long term conditions and 'Good' for the care provided to, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

We gave the practice an overall rating of 'Good'

Our key findings were as follows:

- Patients were overall satisfied with opening times and access to appointments.
- The practice was managed well from a health & safety perspective. Where risks were identified, control measures were in place to minimise them.
- The practice was clean & hygienic, infection control audits were regularly completed and action taken where risks had been identified.
- Staff were trained to respond to emergency situations and the welfare of patients was prioritised.
- Patients said they were treated with compassion, dignity & respect and this was reflected in patient surveys we reviewed.
- Clinical staff followed recognised guidance to deliver effective care & treatment to patients.
- Clinical audit cycles were completed resulting in improved outcomes for patients.
- The practice was well-led. There were clear leadership and governance arrangements in place and staff were supported to deliver effective care.

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

The provider should:

Summary of findings

- Provide staff with access to and training in the use of an automated external defibrillator (used to attempt to restart a person's heart in an emergency) in line with the Resuscitation Council (UK) recommendations for primary care.
- Introduce a whistleblowing policy to ensure staff are aware of the procedures to follow if they had concerns about suspected wrong doing at work relating to other staff members.

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 including safeguarding concerns. Lessons were learned and communicated through staff meetings to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients and staff were assessed and well managed including infection prevention and control audits. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams and used guidance from the National Institute for Health and Care Excellence (NICE) and local commissioners to improve patient outcomes. We saw evidence of completed clinical audit cycles and improved patient outcomes as a result. The practice had analysed its Quality & Outcomes Framework (QOF) performance and had formulated action plans to improve QOF performance, for example in the management of diabetes.

Are services caring?

Good

The practice is rated as good for providing caring services. Patient satisfaction was higher than the local Clinical commissioning Group (CCG) average. Patients said they were treated with respect, dignity and compassion by the staff team and this was reflected in the patient surveys we reviewed. Patients said that the GPs and nurses provided sufficient information to enable them to make informed decisions about their care and treatment. Patients were supported through periods of bereavement and following the diagnosis of serious illness.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was well equipped and had adequate facilities to meet patients' needs. The GPs understood the needs of the local population and prioritised patients accordingly. A range of appointments were available at times to suit patients' specific needs. The practice scored in line with the local CCG average in the national GP patient survey 2014 for patients overall experience of making an appointment. However, some patients we spoke to and

Summary of findings

comment cards received fed back that it was often difficult to get an appointment with their preferred GP. The practice were aware of this and had employed a salaried GP to improve access. The practice had a system in place for handling complaints and it was working effectively.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a mission statement and it was understood by staff. There was clear leadership in place and staff felt supported in their job roles. Governance arrangements were in place including lead roles for staff and policies and procedures for staff to follow. Staff were aware of who to report to if they had any concerns. The practice sought feedback from patients and staff and acted on it. Staff received annual appraisal where their performance was assessed and areas for development and training were identified.

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. The practice had developed care plans for all patients over 75 years and they also had a named GP. The practice held monthly multidisciplinary team meetings to plan care for older patients and those in need of end of life care. Staff had received training in safeguarding vulnerable adults and were aware of the procedures for reporting any concerns. Home visits were available for older patients who were housebound.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice provided clinics for patients with long-term conditions and these patients were reviewed appropriately. The practice had analysed its QOF performance and formulated action plans to improve the management of patients with long-term conditions, for example those patients with diabetes. The GPs had lead roles for the management of specific long-term conditions and worked in conjunction with the practice nurses to improve outcomes for patients.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided family planning services, post natal clinics and child development checks. The practice offered the full range of childhood immunisations and had performed in line with the local CCG averages for uptake. The practice also provided whooping cough vaccinations for pregnant women between 28 & 38 weeks and MMR (measles, mumps & rubella) vaccinations targeted at 10 to 16 year olds. The practice had a designated GP responsible for child protection and all staff were appropriately trained. The practice liaised with the health visitor and school nurse to identify children at risk.

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 provided extended hours on Mondays from 18:00 – 21:00 exclusively for working age patients. NHS health checks were offered to patients between 40 and 75 years old and latest figures showed that out of 60

Summary of findings

patients offered a health check in the previous three months 51 patients had been screened. Appointments were available via the patient website to accommodate working age patients and telephone consultations were also available for minor ailments.

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 prioritised appointments for vulnerable patients such as those with learning disabilities, older patients and those whose first language was not English. Longer appointments were also available for these patients. The practice had a register of patients with learning disabilities and we found all these patients had received annual health checks. The practice had an 'open door' policy and did not discriminate based on patient's circumstances such as being homeless.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had a register of patients experiencing poor mental health and had identified these for a care plan. The practice offered a new enhanced service called 'shifting settings of care.' This was a joint initiative where the practice worked with the acute mental health trust to manage patients with poor mental health in the community after they had been discharged from hospital. This service involved a mental health specialist providing monthly clinics at the practice to improve care and treatment for these patients. Carer's who were looking after someone with dementia were signposted to support services and regular bulletins raising awareness of dementia were available in the waiting room of the practice.

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What people who use the service say

We spoke with five patients during the course of our inspection including three members of the Patient Participation Group (PPG). We reviewed eight completed Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed the results of the practice's most recent patient experience survey and the 2014 national GP patient survey. Patients were overall satisfied with the service in terms of access, care provided and the professionalism of the staff team. However, some patients we spoke to and comment cards received, fed back that it was difficult to get an appointment with a preferred GP. The results of the national GP patient survey 2014 where there was a 35% response rate (121 responses out of 346 surveyed) showed that the practice scored above the local CCG average in a range of areas including access, overall satisfaction with the practice and clinical staff involving patients in decisions about their care and treatment. These results were also aligned to the practices' own annual patient survey carried out in 2014.

Areas for improvement

Action the service SHOULD take to improve

Provide staff with access to and training in the use of an automated external defibrillator (used to attempt to restart a person's heart in an emergency) in line with the Resuscitation Council (UK) recommendations for primary care.

Introduce a whistleblowing policy to ensure staff are aware of the procedures to follow if they had concerns about suspected wrong doing at work relating to other staff members.

Eastmead Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP who was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Eastmead Avenue Surgery

Eastmead Avenue Surgery is situated at 20 Eastmead Avenue, Greenford, Middlesex, UB6 9RB. The practice provides primary care services through a GMS (General Medical Services) contract to 6300 patients in the local area. The practice is part of the NHS Ealing Clinical Commissioning Group (CCG) which is made up of 80 GP practices. The practice serves a young population group with the number of patients under the age of 40 above the England average. Forty percent of patients are from Black and minority ethnic communities. Long-term conditions are prevalent with diabetes having the highest incidence. The practice staff comprises four GP partners (three female, one male), practice manager, two practice nurses, diabetic nurse specialist, healthcare assistant and a team of reception/administration staff. The practice is a GP training practice with two GP registrars. Patients are referred to the NHS 111 service and another provider for out-of-hours care.

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

The practice offers a range of clinics and services including post natal clinics, child development checks, Immunisations, long-term condition clinics, anticoagulation monitoring, coil fitting, minor surgery, phlebotomy, family planning, travel vaccinations and cervical smears.

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

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.

Detailed findings

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:

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 January 2015. During our visit we spoke with a range of staff including four GPs, practice manager, practice nurse, two administration/reception staff and five patients who used the service including three members of the Patient Participation Group (PPG). We reviewed eight completed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a recent incident had involved the back door of the practice mistakenly being left unlocked. The incident had been reported and the action taken to ensure it did not happen again.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could evidence a safe track record over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at records of significant events that had occurred during the last 12 months. Significant events were a standing agenda item at practice meetings and annual audits of significant events had been completed to look for trends and themes. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and told us they were encouraged to do so.

We saw incident forms were available on the practice computer system. Once completed these were sent to the practice manager who showed us the system she used to ensure these were managed and monitored. We tracked six incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example, one incident reported involved the fax machine malfunctioning which caused disruption to the communication of urgent two week cancer referrals. The practice took action to repair the fax machine and in the meantime had made arrangements to use the fax machine of another local practice.

National patient safety alerts were disseminated by the practice manager via email to relevant staff and acted on. For example, one such alert involved a batch of faulty nebuliser adaptors. The practice had acted on the alert by ensuring that any affected nebulisers were returned to the supplier and replaced.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Clinical staff had completed children protection training to Level 3 and non-clinical staff to Level 1. All staff had completed training in safeguarding vulnerable adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children and had been trained to fulfil this role. All staff we spoke to were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The practice's chaperone policy was publicised on the waiting room noticeboard. Chaperone training had been undertaken by all nursing staff, including health care assistants. If nursing staff were not available to act as a chaperone the receptionists had also undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. Criminal checks via the Disclosure & Barring Service (DBS) had been carried out on all staff acting as chaperones.

Good

Are services safe?

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

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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 the relevant waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice did not hold any stocks of controlled drugs.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy. All staff received induction training about infection control specific to their role and there after annual updates. We saw evidence the practice had carried out infection control audits. We viewed the latest audit and found that any improvements identified for action were completed on time. For example, sharp containers had been appropriately labelled and a protocol for the decontamination of peak flow meters had been put in place as a result of the audit.

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

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

The practice had completed a risk assessment for legionella (a germ found in the environment which can contaminate water systems in buildings) to ensure risks associated with legionella were minimised.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was within the last twelve months. A

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

Staffing and recruitment

We looked at the recruitment records of a cross section of staff. The records contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

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

The practice did not use locum agencies however they used GPs who were previously GP registrars at the practice as locums, as and when required.

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. The practice had commissioned a professional company to carry out annual health and safety monitoring of the practice. This included risk assessments for infection control, legionella, fire and the general environment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and the practice manager was the identified lead for health and safety.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. For example, as a result of risk assessment automatic doors had been installed at the entrance to the practice to allow for disabled access and the rear exit of the practice had been fitted with a fire door to aid evacuation in the event of a fire. We also saw that any risks were discussed at GP partner's meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support and this had been updated annually. Emergency equipment was available including access to oxygen cylinders. All staff asked knew the location of this equipment and records we saw confirmed these were checked weekly. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and had not completed a risk assessment to identify and mitigate the risks of not having access to one.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest (sudden stop in blood circulation due to failure of the heart), anaphylaxis (severe allergic reaction), angina (chest pains caused by reduced blood flow to the heart) and hypoglycaemia (low blood sugar). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that could impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather and infectious disease outbreaks. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. All staff had access to the plan.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and local commissioners. They were also aware of national strategies and programmes and the Mental Capacity Act 2005. Guidelines were accessible to all clinical staff via the shared drive on the practice computer system. GPs attended educational meetings with the GP registrars in training at the practice, in order to discuss new updates and guidance.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. For example, we saw records of patients who had had their long-term conditions reviewed in the previous twelve months and letters inviting patients in to the practice for a review were documented. Procedures were also in place for reviewing patients discharged from hospital and those seen by out-of-hours services.

The GPs told us they led in specialist clinical areas such as diabetes, chronic obstructive pulmonary disease (COPD) and asthma. The practice nurses supported this work which allowed the practice to focus on patients with these specific conditions.

The practice referred patients to secondary care and other community care services in line with national guidance including urgent two week wait referrals for suspected cancer. Data showed the practice was in line with Clinical Commissioning Group (CCG) referral rates to secondary and other community services for most conditions.

We found that accident & emergency admissions were higher than the local CCG average. The practice was aware of this and was looking at ways of reducing the number of admissions. For example, the practice was providing a new enhanced service (services which require an enhanced level of service provision above what is normally required under the core GP contract) to reduce unnecessary admissions to secondary care of 'at risk' patients. The practice was also part of a commissioning incentive scheme whereby the local CCG sent the practice a list of patients with high accident & emergency attendances. The identified patients were then invited in to the practice for a review of their needs.

The practice had developed care plans for all patients over 75 years and those with complex needs. All patients over 75 years old also had a named GP.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, gender and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had achieved 82.1% in their Quality and Outcomes Framework (QOF) performance in the year ending April 2014 which was below national and local CCG averages. The QOF is a system to remunerate general practices for providing good quality care to their patients. The QOF covers four domains; clinical, organisational, patient experience and additional services. There was a lead GP responsible for QOF and the practices' performance was an agenda item discussed at meetings which helped the practice to focus on areas where services to patients could be improved. From the previous years performance the practice had identified a number of areas for improvement including diabetes and hypertension. The practices' performance was particularly low in diabetes where they had achieved only 52.8% of the QOF points available. The practice had formulated an action plan to improve outcomes for patients with diabetes. This included a new diabetic nurse specialist in post since December 2014, a review of all patients with diabetes, the development of a robust recall system and the training up of the locum practice nurse and health care assistant to run diabetic clinics to improve outcomes for patients and meet QOF targets.

The practice showed us four clinical audits that had been undertaken over the previous two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, a referral audit carried out in 2012/13 showed that orthopaedic and cardiology referral rates were higher

than the local CCG averages. The audit was discussed in a clinical meeting and actions to reduce referral rates agreed. A re-audit carried out in 2013/14 showed that referral rates had improved and were now in line with the CCG averages.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the QOF. For example, we saw an audit regarding the prescribing of simvastatin (medicine prescribed to lower cholesterol) in patients also taking amlodipine (medicine prescribed to lower blood pressure). Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the NICE guidelines. The practice had re-audited and documented the success of any changes.

Other examples of clinical audits included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance. However, at the time of our inspection no minor surgery was being carried out due to the GPs other work commitments. We also saw audits of intrauterine contraceptive device (IUCDs) insertions completed annually in line with the Faculty of Reproductive Health Care guidelines.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice was performing in line with other practices in the local area in terms of referral rates for most conditions. The practice participated in peer review with other practices in the CCG through monthly network meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, safeguarding children and adults, fire safety and infection control. A good skill mix was noted amongst the doctors with one GP having an additional diploma in gastroenterology (disorders of the digestive system) and the other GPs having diplomas in obstetrics and gynaecology (which comprises the care of pregnant women, their unborn children and the management of diseases specific to women). All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff had received a comprehensive induction programme when they started working for the practice.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses such as customer care training. As the practice was a training practice, doctors who were in training to be qualified as GPs had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and INR monitoring for patients prescribed warfarin (a medicine for the prevention of blood clots).

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out-of-hours providers and the 111 service were received both by fax and by post. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and said the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patients e.g. those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and the community matron and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a new enhanced service called 'shifting settings of care.' This was a joint initiative where the practice worked with the acute mental health trust to manage patients with poor mental health in the community after they had been discharged from hospital. This service involved a mental health specialist providing monthly clinics at the practice to improve care and treatment for these patients.

Information sharing

Patients were referred to other services/specialists through the referral facilitation service (a central system where referrals are checked for appropriateness). We found the practices referral process was efficient and in line with national guidelines. Patient feedback showed they had no issues with the referral process. Patients said the GP's always referred them promptly and where offered a choice where possible.

The practice had systems in place to provide staff with the information they needed. An electronic patient record (SystmOne) was used by all staff to coordinate, document and manage patients' care. The practice had changed from Emis to SystmOne recently. All staff had been fully trained on the system, and commented positively about the system's safety and ease of use despite finding it difficult initially. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. For example, when carrying out smear tests for patients with learning disabilities. All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). We saw evidence that staff received regular updates and training in the Mental Capacity Act 2005, Deprivation of Safeguard Liberties (DOLs) and Gillick and Fraser competencies.

There was a practice policy for documenting consent for specific interventions. For example, for the fitting of intrauterine contraceptive devices, a patient's written consent was documented in the electronic patient notes. We saw examples of written consent relating to a range of circumstances including where patient's requested a chaperone, where patients were aged over 75 years old and had a care plan, and also where patients had complex needs.

Health promotion and prevention

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

The practice also offered NHS Health Checks to all its patients aged 40-75. Latest figures showed that out of 60 patients offered a health check in the previous three months 51 patients had been screened.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities. The practice had eleven patients on the register and records showed that all had received a check up in the last twelve months. The practice also kept a register of patients with severe mental illness. There were 65 patients on the register and the practice was in the process of developing care plans for them.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all childhood immunisations were in line with the local CCG averages. Other immunisations offered included shingles for eligible patients over 70 years, whooping cough for pregnant women between 28 & 38 weeks and measles, mumps & rubella (MMR) targeted at 10 to 16 year olds.

The practice offered cervical screening and their QOF performance in the previous year was 94.6%.

The practice offered a range of clinics and services including post natal clinics, child development checks,

Good

Are services effective?

(for example, treatment is effective)

Immunisations, long-term condition clinics, anticoagulation monitoring, coil fitting, minor surgery, phlebotomy, family planning, travel vaccinations and cervical smears.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and the practices' annual patient satisfaction survey. We spoke to five patients during our inspection and also reviewed nine Care Quality Commission (CQC) comment cards completed by patients prior to our inspection. The evidence from all these sources showed patients were satisfied with their GP practice. For example, the results of the national patient survey showed that 80% of respondents described their overall experience of the practice as 'good' and 73% would recommend the practice to someone new in the area. Both these results were above the local CCG average and aligned with patients feedback during the inspection including comment cards received. National patient survey data showed that 89% of respondents had confidence and trust in the last GP they saw or spoke to and 81% had confidence and trust in the last nurse they saw or spoke to. We noted the consultation room doors were closed during consultations so private conversations could not be overheard, respecting patients privacy.

All the patients we spoke with said that they were treated with respect, dignity and compassion by the practice staff and this was also reflected in the comment cards we reviewed. Patients said the care was satisfactory and staff were friendly, understanding and helpful. This evidence aligned with the practices annual satisfaction survey and the national patient survey. For example, data from the national patient survey showed 82% of respondents were happy with the helpfulness of receptionists, 88% said the last GP they saw was good at listening to them and 76% said the last nurse they saw was good at listening to them. All these results were either in line with or above the local CCG averages. The practice also scored positively in terms of the GPs and nurses giving patients enough time and treating them with care and concern with all results showing above the local CCG averages.

Care planning and involvement in decisions about care and treatment

The results of the national patient survey showed that 81% of respondents said the GPs were good at explaining tests and treatments and 75% said the GPs were good at involving them in decisions about their care. The results for the nurses being good at explaining tests and treatments and involving patients in decisions about their care were 74% and 67% respectively. All these results were above the local CCG averages and aligned with the practice's annual satisfaction survey. Patients told us that the GPs and nurses explained their conditions to them in sufficient detail and made them aware of different treatment options available. We also saw examples of where written consent was gained from older patients for the development of care plans and consent to carry out medical procedures such as the fitting of interuterine contraceptive devices.

An interpreter service was available for patients whose first language was not English to help them with their communication needs to ensure they could understand treatment options available and give informed consent to care.

Patient/carer support to cope emotionally with care and treatment

Patients told us that staff responded compassionately when they needed help and supported them when required. Staff told us that sympathy cards were sent out to patients who were going through periods of bereavement and the GPs provided us with examples of the support they gave patients recently diagnosed with serious illness.

Notices in the patient waiting room and on the patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the range of support available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs 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 these identified needs. The practice used the BIRT (Business Development & Reporting Tool), which helped doctors detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice was proactive in prioritising the needs of its patients. The GPs attended network meetings with other practices in the CCG to discuss local needs and service improvements that needed to be prioritised. For example, a recent meeting was held to discuss how access could be improved across the CCG. The practice prioritised appointments for vulnerable patients. For example, those with learning disabilities, older patients and those whose first language was not English. Longer appointments were available for these patients.

There had been very little turnover of GPs during the last three years which enabled good continuity of care. Some patients we spoke to and comment cards received fed back that it was often difficult to get an appointment with a preferred GP. The practice manager told us that a salaried GP was starting with the practice which would help to improve access to a GP of choice. In addition the diabetes nurse had retired in the previous year which had impacted on diabetes care. The practice manager told us that they had encountered problems with recruiting a new nurse but this had been resolved with the employment of a diabetic nurse consultant since December 2014.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The PPG was made up of nine volunteer patients who were representative of the patient population. The PPG met with the practice every two months to feedback patients' views and opinions. They were also involved in the analysis of the practices' annual satisfaction surveys and devising action plans based on these. We reviewed the action plan for 2013/14 and found that all the points identified for action had been implemented. These included customer care training for reception staff, a complaints notice displayed in the waiting room and music in the waiting room for patients to listen to while waiting for their appointment.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example patients with learning disabilities were prioritised for appointments and patients who required an interpreter were given double appointment slots. The practice also registered patients who were temporary residents. At the time of our inspection there were no homeless patients however a GP told us the practice had an 'open door' policy for all members of the community.

The practice had access to online and telephone translation services and staff spoke a number of different languages including German, Spanish, Polish, Urdu and Punjabi. Information on the patient website was also available in a variety of languages and the electronic check-in system at the practice was accessible in languages common to the local area.

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

The premises and services had been adapted to meet the needs of people with disabilities including a ramp and automatic doors at the main entrance and toilet facilities to accommodate wheelchair users.

Access to the service

The practice opening hours were 8:00 to 18:00 Monday to Wednesday, 8:00 to 13:00 Thursday and 8:00 to 17:30 on Fridays. Extended hours were available on Mondays until 20:00 for working patients only and by appointment. The practice was closed on Thursday afternoons and weekends. Out-of-hours cover was provided by the NHS 111 service and a local GP deputising service. Telephone consultations could be booked through reception and home visits could be arranged for those patients who were

Good

Are services responsive to people's needs?

(for example, to feedback?)

housebound. Patients could make an appointment by telephone, the patient website or visiting the reception during opening hours. Repeat prescriptions were available within 48 hours by written request.

We reviewed the results of the national patient survey which showed that patients were overall satisfied with access. For example, 79% of respondents were satisfied with the practice's opening hours and 91% of respondents were able to get an appointment to see or speak to someone the last time they tried. Both these results were above the local CCG averages. We also found that the number of respondents describing their experience of making an appointment as 'good' was in line with the local CCG average. However, we also found some results were below the local CCG average. For example, the number of respondents who usually waited 15 minutes or less after their appointment time to be seen, and the number who said the last appointment they got was convenient. Feedback we received from comment cards and patients was generally positive around access although some patients said it was difficult to see their regular GP.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The 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 and all staff received mandatory training in complaints handling.

We saw that information was available to help patients understand the complaints system including posters displayed in the practice and the patient information leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at twelve complaints received in the last twelve months and found that these were satisfactorily handled and dealt with in a timely way. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the latest available report from 2014 and noted that although no themes had been identified, lessons learnt from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice's mission statement was; 'We will endeavour to provide the highest possible standards of care within available resources and aim to make this readily and equally accessible to all our patients regardless of age, sex, disability, ethnicity, language or educational status. We intend to do this from a supportive, happy working environment, with an efficiently run practice, and staff who are well trained and properly rewarded.'

The mission statement was displayed on the patient website in the practice waiting room and in the patient information leaflet for patients to view. Staff we spoke to were aware of the mission statement and they were able to articulate it.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were accessible to staff via the practices' computer system. We looked at a number of these policies and found they had been reviewed annually and were up to date. Policies we reviewed included confidentiality, access to medical records, and complaints. We found that all policies were reviewed on an annual basis.

The practice had an action plan in place which covered all aspects of the running of the practice including human resources management, finance, information technology, premises, QOF and training. The action plan was monitored for completion and updated annually.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed the practice had achieved 82.1% of QOF points available in the year 2013/14. The practice had a lead GP responsible for QOF and we found that QOF performance was discussed at team meetings and plans put in place to maintain or improve outcomes as necessary.

The practice participated in benchmarking and audit. The practice had benchmarked its performance against other practices in the local CCG through monthly network meetings. The practice was performing in line with the CCG average in terms of referral rates and accident & emergency attendances.

The practice participated in clinical audit and we saw evidence of completed audit cycles that showed improved outcomes for patients. These included audits of referrals to secondary care and audits linked to medicine management.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example individual GPs took lead roles for staffing, commissioning, QOF and safeguarding. The nurses led on infection control, medicines and emergency equipment and the practice manager led on complaints, health & safety and the PPG. We spoke with four members of staff who were clear about their own roles and responsibilities. They all told us they were valued and supported in their job roles.

A variety of meetings took place on a monthly basis. For example, partner meetings, clinical meetings, reception/ administration meetings and multidisciplinary team meetings with other health care professionals. We saw minutes of quarterly full team meetings where a variety of topics were discussed including complaints, incidents, QOF and the appointment system. The GPs also attended network meetings where important topics such as access were discussed.

The GP executive partner had one session per week 'protected time' to concentrate on CCG business, audits, and targets such as QOF.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the practices' recruitment policy, stress at work policy and staff support policy. Staff we spoke with knew how to access these policies and the policies had been reviewed on an annual basis.

The practice did not have a whistleblowing policy to ensure staff were aware of the procedures to follow if they had concerns about suspected wrong doing relating to other staff members. Staff we spoke to were not aware of the procedures.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice also had a patient newsletter which contained a section for patients to provide feedback to the practice.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG contained representatives from various population groups; including those that were retired, working age patients, those with long-term conditions and carer's and also reflected the local diverse community. The PPG had carried out annual surveys and met every two months. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

The practice had gathered feedback from staff through appraisals, staff meetings and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that the management team were happy to send them on courses if they requested. Staff told us they were involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

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

The practice was a GP training practice and had GP registrars working at the practice to gain further experience in general practice. We were unable to speak with any GP registrars during our inspection to get feedback on the mentoring and support they received as they were not available.

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients.