Earls Court Medical Centre

Quality Report

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Date of inspection visit: 5 May 2015
Date of publication: 09/07/2015

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Earls Court Medical Centre on 5 May 2015. The practice had previously been inspected during our pilot phase in May 2014. We must conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

Staff understood and fulfilled their responsibilities to raise concerns and report incidents, accidents and significant events.

Staff received adequate support and training to deliver effective care.

Patients said they were treated with compassion, dignity and respect. Information was provided to help patients understand the care available to them.

The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and complaints were dealt with in a timely way.

There were governance arrangements in place and staff understood their level of responsibility and accountability.

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

The provider should:

Summary of findings

Carry out minor surgery audits as recommended by the Royal College of General Practitioners (RCGP).

Provide access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency) as recommended by the UK resuscitation council guidelines.

Formalise the practice's vision and strategy.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Clinical audits were completed which showed improved outcomes for patients. Staff worked with multidisciplinary teams. Staff had received training appropriate to their roles and annual appraisals.

Are services caring?

Good

The practice is rated as good for providing caring services. Although the results of the National GP survey 2014 was mixed, feedback from patient's we spoke with on the day of our inspection and comment cards reviewed showed they were treated with compassion, dignity and respect and involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said there was good continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice dealt with complaints in a timely way. Learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a vision that was shared with staff and they understood their responsibilities in relation to it. There was a clear leadership structure and staff felt supported and valued. 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 sought feedback from staff and patients, which it acted on. The practice had a virtual Patient Participation Group (PPG) which the practice engaged with to improve services to patients. Staff had received inductions, attended staff meetings and received training and appraisals.

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 a lower than National average number of older patients. The percentage of over 75 years was 4.5% and over 85 years was 1.3% (National average 7.6% and 2.2% respectively).

All patients over the age of 75 had a named GP to provide good continuity of care. The practice offered care planning for older patients, annual reviews and longer appointments with the clinicians. All patients over 75 years had a care plan in place including those on the palliative care register. The practice monitored unplanned admissions to secondary care of older patients, reviewed individual cases and shared learning at clinical meetings. The practice held monthly multidisciplinary team meetings which were attended by the GPs, nurses, health care assistant, district nurses, case managers and social workers to manage older patients. The practice offered a home visiting service for house bound older patients. Patients at risk of hospital admission and readmission were managed with support from the rapid response service, community independence service and the reablement team. The practice also worked closely with the local palliative care team as needed.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 56.7% and 57.5%. These were higher than the England averages of 54% and 48.8%.

There were named GPs who led on specific long-term conditions such as diabetes and asthma. All the clinical staff undertook regular update training in long-term conditions and they attended weekly clinical update meetings in-house. The practice had a high prevalence of patients with diabetes and to meet their needs the GPs worked closely with the local diabetes specialist and provided joint consultations to optimise care for the most complex cases. The practice nurse also worked closely with the community diabetic nurse. All patients with long-term conditions were invited in to attend annual reviews with a GP or nurse. There was a primary care navigator service based at the practice who signposted patients to supported self-care and self-management services. Patients were also referred to the expert patient program. (A self-management programme for people living with a long-term condition).

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice had a lower number of children aged 0 to 4 years compared to the National average (3.1% compared to 6%) and a lower number of children aged 5 to 14 years (5.7% compared to 11.4%). The percentage of children aged under 18 years was also below the national average (7.7% compared to 14.8%).

The practice provided same day urgent access for children and pregnant women. The practice held weekly baby and children's clinics that ran alongside health visitor clinics. Weekly immunisation clinics were held by the practice nurse. The GPs, nurse and health visitor worked together to monitor at risk families. All staff were trained in child protection to the appropriate level and safeguarding concerns were escalated when necessary. The practice provided bi-weekly routine antenatal clinics and worked closely with the local midwife service. The practice offered family planning and sexual health screening services, particularly to younger patient groups.

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 percentage of patients in paid work or full time education was 69.3% which was above the national average of 60.2%.

The practice offered a variety of health promotion and screening services to working age people, including NHS health checks, cervical screening, breast cancer, bowel cancer and HIV screening. Other services included foreign travel advice and inoculations, stop smoking service and an alcohol support service. The practice ran commuter clinics five days a week, four evenings a week and Saturday mornings. The practice provided a collaborative walk in service at weekends for patients requiring urgent care outside of routine GP hours. Online services were available including repeat prescription ordering, booking appointments and access to medical records. The practice also provided a text message appointment reminder service which was particularly useful for working age people.

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 had an open access policy for vulnerable patients including homeless and disabled patients. The practice building was fully compliant with the Disability Discrimination Act (DDA) including

ground floor consulting rooms, accessible toilets and hearing loops for those patients who were hard of hearing and staff had received some basic training in sign language. Reception staff spoke a number of languages and had access to translator services for those patients whose first language was not English. All staff had received training in safeguarding vulnerable adults and were aware of the procedures to follow if they had a concern. The practice carried out annual health checks for vulnerable patients including those with learning disabilities and the homeless. The practice had systems in place to identify and support carers including signposting them to relevant support groups.

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).

There was a high prevalence of patients with mental health conditions in the locality including severe and enduring mental illness. The GPs took an active approach to managing these patients through working with other health care professionals based at the practice. These included the community psychiatric nurse, counsellors and a cognitive behavioural therapist to provide comprehensive care to patients experiencing poor mental health. The practice also worked closely with the community mental health team and the local drug and alcohol team. The practice signposted patients to other services including the local mental health hub, home treatment and focus teams, the crisis and intervention teams and a consultant psychiatrist. The practice also provided some mental health support to patients who resided at a local mental health step-down facility.

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection and reviewed 12 CQC comment cards which had been completed by patients prior to our inspection. We reviewed data from the 2014 National GP Patient Survey, feedback from patients from the Friends and Family Test (FFT) and patient questionnaires conducted by the practice. All the comment cards we received and patients we spoke with were positive about the service they received from their GP practice. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. The results of the FFT showed that 97% of respondents would recommend the practice. National patient survey data showed that the practice was rated higher than others for several aspects of care including accessing their preferred GP and having confidence and trust in them. However in some areas the practice was rated lower than others including the GPs being good at listening and giving patient's enough time.

Areas for improvement

Action the service SHOULD take to improve

- Carry out minor surgery audits as recommended by the Royal College of General Practitioners (RCGP).
- Provide access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency) as recommended by the UK resuscitation council guidelines.
- Formalise the practice vision and strategy.

Earls Court Medical Centre

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 Earls Court Medical Centre

Earls Court Medical Centre is situated at 248 Earls Court Road, London, SW5 9AD. The practice provides primary medical services through a General Medical Services (GMS) contract to approximately 6200 patients in West London (GMS is one of the three contracting routes that have been made available to enable commissioning of primary medical services). The practice is part of the NHS West London Clinical Commissioning Group (CCG) which comprises 51 GP practices. The practice population is culturally diverse and transient, with a higher than national average of patients aged 30 – 70 years. In contrast the number of older patients and young people under 20 years including children is considerably lower than the national average. Life expectancy is 81 years for males and 85 years for females which is higher than the national average, and the local area is the forth most deprived in the West London CCG (people living in more deprived areas tend to have greater need for health services).

The practice team consists of four GP partners (two male & two female), a practice nurse, a healthcare assistant, a practice manager and a team of reception/administration staff. Other healthcare professionals attached to the practice include a health visitor, community psychiatric nurse, phlebotomist and a mental health liaison nurse.

The practice offers a wide range of clinics including musculoskeletal, childhood immunisations, child health surveillance, antenatal, minor surgery, baby and the management of long-term conditions.Other services include blood tests, physiotherapy and counselling.

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's opening hours are Monday, Tuesday, Wednesday and Friday 8.00 am to 6.30 pm and Thursday 8.00 am to 1.30 pm. Extended hours are on Monday, Tuesday, Wednesday and Friday until 7.30 pm and weekends 9.00 am to 5.00 pm where the practice provides a walk-in service. A walk-in service is also available weekdays. The practice has opted out of providing out-of-hours services to their own patients and directs patients to the NHS 111 service.

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, and to look at the overall quality of the service. The practice had previously been inspected

during our pilot phase in May 2014, and we have an obligation to conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

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 5 May 2015. During our visit we spoke with a range of staff including two GPs, nurse, healthcare assistant, practice manager, two non-clinical staff and spoke with nine patients who used the service. We reviewed 12 completed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example a recent incident reported involved a staff member suffering an anaphylactic reaction. Clinical staff were alerted and the staff member was assessed promptly.

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

Learning and improvement from safety incidents

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

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example one incident we reviewed involved a reissue of repeat medication despite the medication being issued within the same week. We saw evidence that the practice had taken action to prevent recurrence and learning was shared with the relevant staff. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts received from the NHS were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at staff meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. For example a recent alert the practice received was for a defective batch of prefilled adrenaline syringes. The alert was disseminated to the relevant staff and any defective syringes disposed of.

Reliable safety systems and processes including safeguarding

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

The practice had appointed GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including

health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had completed criminal records checks through the Disclosure and Barring Service (DBS) on all staff who acted as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. We found that medicines requiring refrigeration such as vaccines were stored within the required temperature range. The practice held stocks of a controlled drug which was stored safely in a locked area.

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

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received regular updates. We saw evidence that the NHS Commissioning Support Unit had carried out an infection control audit in March 2015 and the practice had achieved 95% compliance. We found that any improvements identified for action were completed on time. For example the audit identified that there was no written protocol for the decontamination of multi-patient use peak flow meters and this was rectified immediately by the practice.

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

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

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

Good

Are services safe?

Staffing and recruitment

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

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

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

Monitoring safety and responding to risk

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

Identified risks were discussed at GP partners' 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. Records showed that all staff had received training in basic life support on an annual basis. Emergency equipment was available including access to oxygen. The practice did not have an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a staff member and that the practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GPs also attended monthly network learning forums led by hospital consultants to discuss specific cases.

The GPs told us they led in specialist clinical areas such as diabetes, palliative care and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

A GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing and outpatient attendances, which were comparable to similar practices. All GPs we spoke with used national standards for the referral of patients with suspected cancers to be seen within two weeks. We saw minutes from both internal and external meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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 had a system in place for completing clinical audit cycles. The practice showed us four clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example one audit we reviewed was to investigate the management of type 2 diabetes mellitus in patients registered at the practice. Patients were assessed for their diabetes control by analysing their performance against four Quality and Outcomes Framework (QOF) indicators (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 audit was completed over three cycles (three years) and for each cycle showed an improved performance for each indicator. The other clinical audits we reviewed included those for cervical cytology conducted by the nurse, referral management audits and prescribing audits completed in conjunction with the Clinical Commissioning Group (CCG) prescribing advisor. However although the practice carried out minor surgery, the practice could not provide evidence of minor surgery audits as recommended by the Royal College of General Practitioners (RCGP).

The practice had achieved 97% in their QOF performance in 2013/14 which was 7.5% above the local CCG area average and 3% above the national average.

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

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had

Good

Are services effective?

(for example, treatment is effective)

outcomes that were comparable to other services in the area. For example referral rates, antibiotic prescribing and outpatient attendances were in line with other practices in the local CCG area.

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 vulnerable adults and infection control. We noted a good skill mix among the doctors with the GPs having a variety of special interests including minor surgery, travel medicine, child health, family planning, cardiology, diabetes and asthma. 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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and support. An induction programme was in place for all new staff members tailored to their roles.

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

Working with colleagues and other services

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

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

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For example when making do not attempt resuscitation decisions.

Good

Are services effective?

(for example, treatment is effective)

Patients with learning disabilities, poor mental health and dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. The practice had nine patients on the learning disabilities register and all had a care plan in place. The practice also had 103 patients on the mental health register and 92 had a care plan in place. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

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

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

The practice had achieved 91.3% in their QOF performance for public health indicators for 2013/14 which was 3.3% above the CCG average and 3.3% below the national average. The practices performance was above CCG/ national averages for cardiovascular disease (primary prevention), child health surveillance, contraception and maternity services.

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

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Data was not available as to how many patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. There were nine patients on the register and all had received an annual physical health check in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. The practice also provided a stop smoking service and had achieved 93.3% in their QOF performance in 2013/14 for smoking indicators which was 4.3% above the local CCG average and 0.4% below the national average.

The practice's QOF performance for cervical screening in 2013/14 was 78.6% which was 8.7% below the local CCG average and 18.9% below the national average. To improve uptake the practice was actively calling in patients eligible for a smear test. The practice offered a number of other screening services including breast cancer, bowel cancer and HIV screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. In the year 2013/14 the practice's performance for children aged 12 months for all vaccinations was above the local CCG average. For example the Meningitis C vaccine uptake was 82.7% compared to the CCG average of 67% and the 5 in 1 vaccine uptake 84.6% compared to the CCG average of 79.7%. However, the practice's performance for children aged 24 months was below the CCG average. For example the Men C booster vaccine uptake was 57.9% compared to the CCG average of 73.9% and the 5 in 1 vaccine uptake was 73.7% compared to the CCG average of 80.7%.

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, the practice's annual patient satisfaction survey carried out in April 2015 and the Friends and Family Test (FFT). The evidence from all these sources showed a mixed response from patients with how they were treated by their GP practice. For example, data from FFT showed that 97% of respondents would recommend the practice. The results of the national patient survey showed that 78% of respondents usually got to see their preferred GP compared to the CCG average of 65%, and 94% of respondents had confidence and trust in the last GP they saw or spoke to. However, the results of the national patient survey showed the practice scored below average for its satisfaction scores on consultations with doctors and nurses with 79% of practice respondents saying the GP was good at listening to them compared to the CCG average of 87% and the national average of 88%, and 77% of respondents saying the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received twelve completed cards and all the feedback was positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us he would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients had a mixed response to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the national patient survey showed 74% of practice respondents said the GP involved them in care decisions which was in line with CCG/national averages. However, 76% of practice respondents felt the GP was good at explaining treatment and results which was below the CCG and national averages of 83% and 82% respectively. The results from the practice's own satisfaction survey showed that 61% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed did not assess emotional support provided by the practice to patients. However the patients we spoke with on the day of our inspection and the comment cards we received were positive in this regard and highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website told patients how to access a number of support groups

Good

Are services caring?

and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. The practice also signposted patients to bereavement support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. For example through work done with the CCG and other local practices it had been established that there was a high incidence of patients experiencing poor mental health in the local community. To provide care for this patient group the practice was actively calling in patients for mental health assessments and worked collaboratively with the community psychiatric nurse and the local psychiatrist to monitor and review their needs.

The practice participated in the unplanned admissions Enhanced Service and used a risk stratification tool to identify patients who were at risk of hospital admissions. The practice had identified 2% of the practice population who were at risk of hospital admissions and care plans were in place to meet their care needs. All patients over 75 years had a care plan in place.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the practice had implemented online services and increased the number of reception/administration staff to improve administration services. The practice had also provided more staff training and was in the process of improving the telephone system.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example longer appointments were available for patients with learning disabilities, older patients, and patients with long-term conditions. Longer appointments were also available for those patients with complex needs. The practice had an open door policy and saw homeless people and asylum seekers as temporary residents.

The practice had access to online and telephone translation services and staff spoke a range of languages. Staff were able to describe various forms of discrimination and recognised the importance of respecting each patient individually irrespective of their colour, race or ethnicity. There was an equality and diversity policy for staff to reference on the shared drive of the practice's computer system.

The premises and services had been adapted to meet the needs of patient with disabilities. The patient waiting area and reception were situated on the ground floor of the practice and the consultation rooms were situated on the first and second floors of the building. There was level access at the entrance to the practice and there was lift access to the first and second floors.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms via the lifts. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available 8.00 am to 7.30 pm on Mondays, Tuesdays, Wednesdays and Fridays, 8.00 am to 1.30 pm Thursdays and 9.00 am to 12.00 pm Saturdays. In addition the practice offered a walk-in service weekdays with a designated GP, and weekends from 9.00 am to 5.00 pm in collaboration with other local practices.

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

Longer appointments were also available for patients who needed them including those with long-term conditions, older patients and those with complex needs. This also included appointments with a named GP or nurse.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with access to appointments and the GPs although survey results were mixed. For example the results of the national patient survey 2014 showed that 78% of respondents with a preferred GP usually got to see or speak to that GP compared to the local CCG average of 68%. National patient survey results also showed that 86% of respondents were able to get an appointment to see or speak to someone the last time they tried which was in line with the local CCG average 86%. However other results showed that the practice scored below the local CCG average for ease of getting through on the phone (48% compared to 86%), patients overall experience of making an appointment (64% compared to 79%) and the time patients had to wait after their appointment time to be seen by a GP (46% compared to 63%). Feedback from patients we spoke with on the day of our inspection including comment cards we received did not highlight any issues with the appointment system.

The practice's extended opening hours on Mondays, Tuesdays, Wednesdays and Fridays until 7.30 pm, Saturdays until 12.00 pm and the weekend walk-in service was particularly useful to patients with work commitments.

Listening and learning from concerns and complaints

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

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

We looked at seven complaints received in the last 12 months and found they had been satisfactorily handled and dealt with in a timely way.

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 vision of the practice was to become a GP training practice and also to build and develop a strong multi-skilled team to deliver quality care to patients. Although the vision was not formalised all staff we spoke with including GPs, the nurse, health care assistant, practice manager and non-clinical staff were able to articulate the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a variety of these policies and procedures and found they had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and individual GPs took lead roles for safeguarding, clinical governance, confidentiality and information governance. The practice manager took the lead for human resources/recruitment, QOF oversight, complaints handling and health and safety. A GP partner was on the governing body of the local CCG and chaired local network meetings. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the last peer review, which showed that the practice had the opportunity to measure its service against others and identify areas for improvement.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. These included audits of referrals, prescribing, cervical cytology and audits related to QOF.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the checks that were in place to monitor a wide range of potential issues. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. These included risk assessments for fire, legionella and infection control.

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

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly including specific meetings for clinical staff, partners, reception staff and the meetings where the whole practice attended. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that a team away day had recently been held.

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice had acted on the results of annual patient surveys, which included increasing the number of reception/administration staff and providing more staff training to meet patient's needs.

The practice had a virtual patient participation group (PPG) which has steadily increased in size. The virtual PPG group included patients from various population groups

Are services well-led?

Good

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

including working age and older patients. The PPG was involved in formulating action plans based on annual surveys. 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 staff meetings, appraisals and away days. Staff told us they would not hesitate to give feedback and 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 electronically on any computer within the practice and staff understood the whistleblowing procedures.

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 six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had recently attended a staff away day. Staff commented that there was good communication between staff and a positive team spirit.

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