Dukes Avenue Practice

Quality Report

1 Dukes Avenue
Muswell Hill
London
N10 2PS
Tel: 020 8365 3303
Website: www.dukesavenuepractice.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Dukes Avenue Practice on 19 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, and responsive services. The practice required improvement for providing a safe service. The practice was also good for providing services for the care provided to 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 and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and that they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care. For example same day urgent appointments were available.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the must:

Summary of findings

- Ensure Disclosure and Barring Service (DBS) checks are carried out for all staff undertaking chaperone duties.

The provider should:

- Ensure legionella testing is undertaken.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. Staff told us there was enough staff to keep patients safe. The practice had systems in place to ensure patients were safe including safeguarding and chaperone procedures, and processes to ensure medicines were correctly handled. Although risks to patients who used the service were assessed and monitored, the practice have a risk log to ensure all risks were recorded and reviewed in monthly meetings. Risks that were identified were discussed in clinical meetings where an action plan would be established before discussing within practice meetings. Patients were treated in a clean environment and processes were in place to monitor infection control. Equipment was fit for purpose and maintained regularly. The safeguarding lead demonstrated good liaison with local social services which included a six-weekly multi-disciplinary meetings. However non-clinical members of staff that were acting as chaperones had not received a Disclosure and Barring Service (DBS) check and a risk assessment had not been carried out to verify the reason for this,

Are services effective?

Good

The practice is rated as good for providing an effective service. Data showed patient outcomes were at or above average for the locality. For example the practice cervical screening rate was 87% compared to the Clinical Commissioning Group (CCG) average of 73.4%. National Institute for Health and Care Excellence (NICE) guidance was routinely referenced and used. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff received appropriate training for their roles and further training needs had been identified and planned. The practice could provide evidence of all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced. The practice was able to demonstrate completed audit cycles where changes had been implemented and improvements made.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others in the locality for several aspects of care. For example, the national patient survey showed that 75% of patients usually waited 15 minutes or less after their appointment time to be seen, which was better than the CCG average of 56%. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the treatment available to them. We saw that staff treated patients with kindness and respect ensuring confidentiality was maintained. The practice had an active Patient Participation Group (PPG) which met regularly to discuss the work of the practice and to develop the annual patient survey. In the latest survey carried out, 90% of patients who responded to the survey rated the practice as either good or excellent. We viewed the national GP patient survey for 2014 that showed 95% of patients would recommend the surgery to someone new to the area, which was above the Clinical Commissioning Group (CCG) average of 71%. The survey also showed patients being satisfied with the opening hours (71%) compared to the CCG average of 72%.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the local Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and 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. There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy to deliver a high level of service to patients. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures, including infection prevention and control and medicines management, to govern activity and regular governance discussions taking place within clinical meetings. There were systems in place to monitor and improve quality and identify risk.

Summary of findings

The practice sought feedback from staff and patients and this had been acted upon. The practice had an active Patient Participation Group (PPG). Staff had received inductions, performance reviews and attended staff meetings.	

Summary of findings

What people who use the service say

During our inspection we spoke with 15 patients at the surgery and collected 32 comment cards that had been completed by patients.

Patients were happy with the service provided and said that they were treated with respect and well cared for. Patients told us that they were involved in the decision making process regarding their treatment, and were given information about all the treatment options available to help them make their choices.

Patients we spoke with who were receiving ongoing treatment were happy with the way their treatment was being managed and they were kept informed at all times.

We viewed the national GP patient survey for 2014 that showed 95% of patients would recommend the surgery to someone new to the area, which was above the Clinical Commissioning Group (CCG) average of 71%. The survey also showed that 75% usually waited 15 minutes or less after their appointment time to be seen, which was above the CCG average of 56%. Areas which the practice had poorer scores included patients being satisfied with the opening hours (71%) compared to the CCG average of 72%. The practice was aware of this and was providing extended hours to address the issue. In the latest patient survey carried out by the practice Patient Participation Group (PPG), 90% of patients who completed the survey were satisfied with the overall service provided by the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure Disclosure and Barring Service (DBS) checks are carried out for all staff undertaking chaperone duties

Action the service SHOULD take to improve

- Ensure legionella testing is undertaken.

Dukes Avenue Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. It included a GP advisor who were granted the same authority to enter the Dukes Avenue Surgery as the Care Quality Commission (CQC) inspector.

Background to Dukes Avenue Practice

The Dukes Avenue Practice is a surgery located in the London Borough of Haringey. The practice is part of the NHS Haringey Clinical Commissioning Group (CCG) which is made up of 51 practices. It currently holds a General Medical Service (GMS) contract and provides NHS services to 11,039 patients.

The practice serves a mainly middle class working population, with an increasing number of non-English speaking patients. Many of the Eastern European languages are spoken within the community. The practice does not have a large older population (14%) and 18% of the population is under the age of 14. The practice is situated within an adapted Edwardian house. Consulting rooms are also available on ground level for those with impaired mobility. There are currently 11 GP's (six male and five female), two practice nurses, a healthcare assistant, administrative staff and a practice manager. The practice is open between 8am and 6:30pm each day. Appointments are available from 8:30am to 6pm on weekdays. Extended hours appointments are available between 6.00pm and 8pm on a Thursday. Telephone consultations, email enquiries and home visits are also offered. The practice opted out of providing an out of hour's service and refers patients to the local out of hour's service.

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

The practice provides a range of services including child health and immunisation, anti-coagulation clinic, smoking cessation clinics and clinics for patients with long term conditions. The practice also provides health advice, blood pressure monitoring, psychiatric clinic and an alcohol misuse clinic, minor surgery and drug advisory clinic.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 19 January 2015, 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 service, and to provide a rating for the service under the Care Act 2014.

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

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 including NHS Haringey Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 19 January 2015. During our visit we spoke with a range of staff including GPs, practice nurse, practice manager and administration staff. We spoke with patients who used the service including representatives of the Patient Participation Group (PPG). We reviewed 32 completed Care Quality Commission (CQC) comments cards and three CQC share your experience forms where patients and members of the public shared their views and experiences of the service. We observed how people were being cared for and reviewed the personal care or treatment records of patients.

Requires improvement

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 the responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an incident was recorded where a child developed a reaction to an undiagnosed nut allergy. The practice dealt with the incident effectively until the emergency services arrived.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were discussed in both clinical and practice meetings and a dedicated meeting was held annually to review actions from past significant events and complaints.

There was evidence that the practice had learned from significant events and that the findings were shared with relevant staff. For example, an incident was recorded involving a medication error where the wrong medicines had been provided by the pharmacy and administered within the practice, resulting in the patient being taken to accident and emergency for observation. This led to a review of the drug administration procedures within the practice. The learning outcomes were shared within clinical meetings and the policy regarding the issue of prescriptions was revised to ensure they were double checked by the GP before issue. Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration at practice meetings and were encouraged to do so.

Staff used standard forms to record incidents and sent them to the practice manager for processing. We were shown the system used to manage and monitor incidents. We tracked six incidents and saw that records were completed in a timely manner. We saw evidence of action that was taken as a result. For example, where elderly house bound patients were visited by the GP without prior warning, the process was changed to ensure that the practice telephoned patients in advance to advise of the visit.

National patient safety alerts 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. For example, a recent alert regarding Ebola was discussed in practice meetings to ensure staff were aware of the signs and the process to follow if there was a suspected case. We were told by staff that all alerts were discussed within the meetings of the relevant staff group where the alert would be of most relevance. For example, a medication recall would be discussed in clinical meetings.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We looked at staff training records which showed that all staff received annual child protection and adult safeguarding training. The training was due for renewal by all staff in April 2015. GP's and nurses were trained to level three and all other staff were trained to level one for child protection. We asked members of medical 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 as well out of normal hours. Contact details were easily accessible within each room.

The practice had nominated GP leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate that they had the necessary expertise to enable them to fulfil the role. All staff we spoke with were aware of who the leads were.

A chaperone policy was in place and signs were visible in the waiting area and in consulting rooms. Chaperone training had been undertaken by nursing staff and reception staff who were on the practice chaperone list. All staff understood their responsibilities when acting as chaperones including where to stand during the consultation. The practice had a detailed chaperone policy

with guidance to follow. However three of the six non clinical staff acting as chaperones had not received a disclosure and barring service (DBS) check and no risk assessment had been completed.

The practice used the required codes on their electronic case management system to ensure that children and young people who were identified as at risk, including those who were looked after or on child protection plans, were easily identifiable. The practice used a risk stratification tool to highlight vulnerable children and adults that were frequent hospital emergency department attenders. Those patients that were flagged were placed on the practice vulnerable patients list which was reviewed in clinical meetings. The safeguarding lead was aware of vulnerable children and adults and demonstrated good liaison with local social services which included a six-weekly meeting with health visitors to discuss children on the register, attending child protection hearings in person or providing a report if unable to attend.

Medicines management

We checked medicines stored in the treatment rooms and within the 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 also described the action to take in the event of a potential failure. An up to date record was kept of fridge temperatures. No breaches in temperature were recorded.

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.

Vaccines were administered by the practice nurse in line with legal requirements and national guidance. We saw evidence that the practice nurse had received the appropriate training to administer vaccines. The practice nurse was also qualified as a prescriber (a nurse qualified to issue prescriptions to patients). The practice did not hold controlled drugs.

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. Prescription pad numbers were recorded before placing in printers 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 that cleaning records were kept. Patients told us they always found the practice clean and had no concerns about cleanliness. The practice employed an external cleaning company and we viewed the cleaning log held by the practice. Any concerns regarding cleaning were raised directly with the company by the practice manager. The practice manager undertook a weekly spot check and reported any issues straight to the cleaning company.

The practice had a nurse 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 also received annual updates.

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. The policy included spillage management, specimen handling and routine equipment decontamination. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The practice had undertaken an infection control audit in January 2015, prior to the CQC inspection. The result of the audit did not show any issues.

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 not arranged for a legionella inspection to be carried out by a competent person. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.

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 (July 2014). A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example baby scales, diagnostic sets, digital blood pressure monitors, spirometers, thermometers, ultrasound and vaccine fridges. Calibration last took place in July 2014.

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 and registration with the appropriate professional body. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had only undertaken Disclosure and Barring Service (DBS) checks for clinical members of staff However, three of the six non-clinical staff who acted as chaperones had not received a DBS check. A risk assessment had not been carried out to identify the risk of staff not receiving a DBS check.

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 was 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. Newly appointed staff had this expectation in their contracts. The practice manager maintained a staffing matrix to ensure enough staff was present to cover the practice and to plan for any shortage of staff through sickness, external training or annual leave. There was a practice policy to train non-clinical staff to carry out a number of different duties to ensure that all staff were able to cover any position. For example back office administrative staff were also trained in reception duties to allow cover in times of staff sickness.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe which was evidenced through the staff rota system.

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, 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.

Risks identified within the practice were centrally logged and discussed within monthly clinical team meetings where an action plan would be established. The plan would then be disseminated to the remainder of the staff team through the practice meeting.

We saw that staff were able to identify and respond to changing risks to patients including their health deteriorating. Staff gave examples of where they had spoken with patients or their relatives and identified a change in the patient's wellbeing. The staff members then relayed the information to the duty doctor to follow up with the patient, if appropriate. For example, when a change in a person's long term illness or the onset of dementia had been identified. We also saw how patients that were experiencing a mental health crisis were reviewed by the GP and referred to the local mental health team for an urgent mental health review. Staff spoke about ensuring that patients with a long term condition were referred to secondary care, if it was noticed through their health review that their condition was deteriorating. This was also noted on patient record cards.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were available and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis (a life threatening allergic reaction that can develop rapidly) and hypoglycaemia (low blood sugar level). Processes were in place to ensure that emergency medicines were within their expiry date and

Requires improvement

Are services safe?

that they were replaced on expiry. All the medicines we checked were in date and fit for use. The practice had a contract with an oxygen supply company ensuring that the oxygen supply was replaced prior to expiry.

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, the contact details of a heating company to call 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. The practice had a fire safety log book and tested the fire alarms and emergency lighting on a monthly basis.

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 a spreadsheet which contained minutes of both clinical and 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 told us they lead in specialist clinical areas such as dermatology and Chronic Obstructive Pulmonary Disease (COPD) and the practice nurses supported this work Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers and mental health conditions. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

A risk stratification tool was used to identify patients who may be at a higher risk and in need of a more detailed needs assessment. The tool identified the top 2% of a particular group, for example patients with a high attendance at accident and emergency (including older patients), long term conditions and those patients with mental health concerns. Best practice guidance would then be used to discuss these issues with patients and provide the most up to date care. All unplanned admissions to hospital were reviewed in clinical meetings and we were shown copies of the minutes of the meetings where individual patients were discussed. We viewed care plans for those patients identified and saw how a plan was put in place with the practice to effectively manage their health concerns which included health checks and regular reviews. Patients were referred to local services including the community mental health team for further testing and diagnosis.

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 patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us three clinical audits that had been completed within the last 12 months. As a consequence of the clinical audits, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, an audit of patients with raised ferritin levels was undertaken in August 2014. This identified a number of patients where the levels could have been reduced through early intervention. The audit was discussed at clinical meetings to ensure that clinicians picked up on the signs at an earlier stage. The audit was repeated in December 2014 and showed that the number of patients with raised ferritin levels had decreased. The results of the follow up audit was discussed within practice meetings. The remainder of the audits had yet to complete their first audit cycle.

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local Clinical Commissioning Group (CCG) as a whole against the national average. The latest available QOF data showed that overall the practice is performing above the CCG average (90.9%) and the

Good

Are services effective?

(for example, treatment is effective)

national average (93.5%) achieving 99.3%. This was a general figure which included all areas that QOF covered (clinical care, how well the practice was organised, patient viewed, amount of extra services offered by the practice). The practice used this information to ensure that it was on target to deliver a good service and to discuss, in both clinical and practice meetings, how the service could be improved.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, 66% of patients over 65 years of age had received a flu vaccination, and 75% of patients with diabetes had received an annual review. The practice results did not fall outside the range used to assess the results or any QOF (or other national) clinical targets.

The clinical team was making use of Clinical Commissioning Group (CCG) benchmarking against other practices which included reviewing patient attendance at accident and emergency (A&E). Patients were contacted by the practice where A&E attendance could have been avoided by raising awareness of other alternative local services. Clinical meetings were used to discuss and reflect on how the systems at the practice could be improved to achieve outcomes for patients.

Staff checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that patients had received appointments for all routine health checks for long term conditions such as diabetes and that the latest prescribing guidance was being used.

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. We noted a good skill mix among the doctors with one having a certificate in the management of drug misuse and another with a post graduate rheumatology diploma. All GPs were up to date with their yearly continuing professional development requirements and all were to be revalidated by the end of 2015. (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 funding for relevant courses dependant on business need. For example one member of staff took further training to be able to handle the petty cash system and the clinical administrator was given further training in order to carry out spirometry.

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 and cervical cytology. Those with extended roles, such as undertaking asthma reviews and the monitoring of diabetes and chronic obstructive pulmonary disease (COPD) were also able to demonstrate that they had appropriate training to carry out these duties.

Staff files we reviewed showed that where poor performance had been identified, appropriate action had been taken to manage this.

Working with colleagues and other services

The practice engaged with other health services to ensure a multi-disciplinary approach to the care and treatment of those with complex care issues.

We were informed that the practice had good working relationships with health visitors, midwives, the palliative care team and local mental health teams.

Blood tests, X ray results, hospital letters, information from out of hour's providers and the 111 service were received by the practice electronically, reviewed by the administration staff and passed to the GP or nurse to take the appropriate action within 48 hours. All staff understood their role and felt that the system in place worked well.

The practice held weekly multidisciplinary conference calls to discuss the needs of complex patients, for example those with long term conditions and patients on the mental health register. The conference calls were joined by any member of the hospital team involved in the patients care, community psychiatrist and the manager of the care home that the practice services. The practice also had six-weekly meetings with the community team to discuss vulnerable adults and children. The meetings were attended by community matrons, district nurses and social workers as necessary. Decisions about care were documented in a record card accessible to all members of staff at the surgery

Good

Are services effective?

(for example, treatment is effective)

to enable continuity of care. The practice also held a quarterly palliative care meeting attended by the local multidisciplinary care team including, practice GPs, nurses and the palliative care nurse. We reviewed the minutes for the last two meetings which provided a patient update and the action that was to be taken. We were told that further meetings would be called in the interim period if the need arose.

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 85% 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 was working towards providing information to other services through the shared care record system.

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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

Clinical staff at the practice had received training in the Mental Capacity Act 2005 and the Children's and Families Act 2014. This training had been cascaded to non-clinical staff members through the practice meetings. The clinical staff we spoke with were aware of the key parts of the legislation and were able to demonstrate how it was implemented in practice. For example, staff spoke of the need to ensure appropriate consent for treatment was obtained from a carer or patient with dementia. We were shown evidence of care plans which required consent and found that appropriate consent had been received. The practice maintained a list of those patients who had limited capacity and might need assistance when giving consent.

All clinical staff demonstrated a clear understanding of Gillick competencies (these help clinicians to identify children aged under 16 who have legal capacity to consent to medical examination and treatment). We were provided with the practice policy for determining the capacity of patients under 16 to give consent and the procedure for the practice to follow. The practice maintained a list of patients where Gillick competencies were needed to assess consent. We reviewed five records which showed that verbal consent had been recorded.

Health promotion and prevention

All new patients were offered a consultation with the practice nurse to discuss the patient's lifestyle and to provide information how it might be improved. This included healthy eating and exercise leaflets and smoking cessation advice. Chlamydia testing and advice was also offered as part of the initial patient consultation for those patients within the age range for this testing. Sexual health advice was offered to young people and those who may be vulnerable. Patients were signposted to other health organisations that could be of service if an issue was identified. The practice also offered a full children's immunisation programme. Immunisation rates were above the Clinical Commissioning Group (CCG) rate. For example, in 2013, the practice rate was 96.7% for MMR immunisations and the CCG average was 89.8%. The practice telephoned patients who did not attend for vaccinations as a reminder and to encourage attendance.

The practice shared the care of mothers and children with the community midwives team and the practice nurse to provide antenatal care and support to new parents. This included a joint paediatric check with the local hospital and six-weekly meetings with the health visitor for the care of patients under 5. The practice supported the work of school nurses. Support for the families of premature babies was also given. The practice also operated a register of children at risk or in social services care and GPs attended joint meetings to discuss care. The GP provided a report for the transition of young people in social services care to adult services. Appointments were available outside school times and included extended hours appointments with the nurse on a Thursday between 6:30 pm and 8pm.

Good

Are services effective?

(for example, treatment is effective)

The practice offered annual health checks and advice to all patients, with specific checks for some patients placed on the long term conditions register, which included structured annual reviews, diabetes checks and blood pressure monitoring. Chronic obstructive pulmonary disease (COPD) checks were also carried out and included spirometry checks (measuring lung function). The practice had undertaken annual reviews for 58% of patients on the practice COPD register and all of the patients on the register had care plans. The reviews included a medicines check to ensure medicines were still relevant to the condition. The practice ran a GP- and nurse-led diabetic clinic, as diabetes had been identified as a local health concern. A weekly anti-coagulation clinic also operated, which actively managed 100 patients.

Smoking habits was added to patient records and smoking cessation classes were run on an ad hoc basis. The practice was unable to provide data regarding smoking cessation quit rates as this service was run by a third party organisation. The practice proactively monitored through the practice computer system patients who may be at risk of developing a long term illness. These patients were called in on an annual basis for a health check to monitor any developments.

Patients over the age of 75 had a named GP, care plan and review which was recorded within the notes. Weekly multidisciplinary teleconferences were held with the community matrons to discuss the ongoing needs of older patients. Extended appointments were available for those patients on the practice frailty register. The practice also ran a weekly exercise class for the over 70's. A dedicated doctor was assigned to a local care home to ensure continuity of care. The practice held a register of patients at end of life and held regular meetings to review the register.

The practice held a register of patients with mental health concerns of which currently 88% had an agreed care plan. The practice was in the process of ensuring those remaining received a care plan. The practice provided annual physical health checks to patients on the register along with regular mental health reviews. The practice worked with a dementia advisor in the advanced care planning for patients with dementia and attended multidisciplinary care reviews to discuss these cases. The practice attended meetings with the local mental health teams to discuss the case management of patients on the mental health register, at which the GPs provided regular health reports. The practice held monthly psychiatric clinics so that a consultant psychiatrist could meet with patients at the practice to provide a comfortable service for patients in familiar surroundings. The practice referred patients to the local memory service for assessment.

Flu vaccinations were offered to all patients with 66% of over 65's and 56% of patients on the at risk registers receiving the vaccination. The practice were aware of this and were working to improve on these figures.

The practice had an 87% uptake for cervical screening which was higher than the latest CCG average of 73.4% (2011/2012). The practice was promoting the service by sending reminders to patients that were due for the screen.

The practice supported working age people to return to work through the 'fit note' system. However the practice did not audit these certificates.

The practice had a facility where If the phone line was busy, patients had the facility to send a text message to the practice which was responded to by a member of the reception staff.

Health advice leaflets were available within the reception area or direct from the nurse. However leaflets were only available in English. Patients were signposted to other voluntary organisations for additional support.

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 and annual patient satisfaction survey undertaken by the practice Patient Participation Group (PPG). The evidence from these sources showed patients were positive about the service they received, that they were listened to by staff and treated with respect. Data from the national GP patient survey (302 surveys were sent out and 107 surveys were returned) showed that 95% of patients who responded would recommend the surgery to someone new to the area, which was above the Clinical Commissioning Group (CCG) average of 71%. The survey also showed that 75% usually waited 15 minutes or less after their appointment time to be seen, which was above the CCG average of 56%. In the latest survey carried out by the PPG (741 respondents), 90% rated the practice as either good or excellent.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 32 completed cards and the majority were positive about the service experience. Patients commented that staff were very efficient and involved them in the planning of their treatment. They also told us that the environment was clean and safe.

We also spoke with 15 patients on the day of inspection, which were happy with the service provided.

Staff told us that all consultations were carried out in the privacy of a consulting room. We noted that the doors to the consulting rooms were closed during a consultation to increase confidentiality. The practice provided a chaperone for any patient that made a request for one. Information on the chaperone service was on display in the reception area.

We noted that the waiting area was situated in a room to the side of reception desk to ensure patients were not overheard at the desk by those waiting for an appointment. A room was made available for any patient that wished to talk to a member of staff in private before their consultation.

Staff told us that the practice had a culture of ensuring that equality for patients. For example, patients experiencing poor mental health or in vulnerable circumstances were able to access the service without fear of prejudice, and staff treated them equally.

Care planning and involvement in decisions about care and treatment

Patient survey information that we viewed showed patients responded positively to questions about their involvement in the planning of their treatment. For example, the national GP patient survey showed that 93% of patients said that the GP was good at involving them in their treatment, and 96% said that the GP was good at explaining test results and treatments, which were both above with the Clinical Commissioning Group (CCG) average. The national survey also showed that 93% of patients said the GP's were good at involving them in their care.

Patients we spoke with on the day had no concerns over involvement in their treatment. All patients said that they were fully involved in the decision making process and that all the options for treatment were explained to them. They also told us they felt listened to and supported by staff to make an informed decision about the choice of treatment they wished to receive without being rushed.

Staff told us that translation services were available for patients who did not have English as their first language. Patients were asked by the receptionist if they required a translator and the service was also publicised in reception.

Patient/carer support to cope emotionally with care and treatment

The survey information we viewed showed that people were positive about the emotional support that was provided by the practice. People told us that when they needed emotional support the GP would offer support through providing an appropriate referral to another service or by providing information of how they could access relevant support groups and counselling services. Patients were contacted by the GP following discharge from hospital. Local voluntary and patient support groups were publicised in reception.

The practice had a carer's policy and the practice computer system alerted GPs if a patient was also a carer. We were

Good

Are services caring?

shown written information signposting carers to support groups. Patients who suffered bereavement were telephoned by the GP and invited to the practice to discuss how staff could be of any help.

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 practice engaged regularly with the clinical commissioning group (CCG) them to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery. For example it was identified that there was a need for a nurse trained in anti-coagulation following the resignation of a previous nurse at the surgery. The practice worked with the CCG to provide services to respond to these needs which included appointing an appropriately trained replacement nurse.

The GPs were members of a local GP federation that met monthly to discuss the needs of the area and to ensure that the services provided are appropriate.

The practice had also implemented suggestions for improvements following patient participation group (PPG) feedback. This included the implementation of a credit card reader to enable patients to make payments for private services more easily.

Tackling inequity and promoting equality

The practice had recognised to the needs of different groups in the planning of its services. The practice had access to face to face, online and telephone interpreting services (including British Sign Language) that could be pre booked for appointments if patients requested to use the service.

The premises and services had been adapted to meet the needs of patient with disabilities. This was used infrequently for consultations but the main purpose was to enable patients to participate in PPG and other practice meetings. Wider doorways were in place to accommodate wheelchairs. 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. Accessible toilet facilities were available for all patients attending the practice, as were baby changing facilities.

The practice actively supported patients who have been on long-term sick leave to return to work by the promotion of the 'fit note' scheme and on-going counselling and support.

Access to the service

The practice was open between 8am and 6:30pm each day. Appointments were available from 8:30am to 6pm on weekdays. Extended hours appointments were available between 6pm and 8pm on a Thursday. Appointments were available with both the GP's and nurse.

Comprehensive information was available to patients about appointments on the practice website and within the practice 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.

The practice was working with a local federation in order to be able to provide doctor and nurse appointments on a Saturday, which had been running since December 2014

Appointments were triaged by the duty doctor. Longer appointments were available for patients who needed them and those with long-term conditions or where an interpreter or advocate may be required. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one. Telephone appointments were carried out by the duty doctor and were available each day for patients unable to attend the practice or those in need of health advice from a GP.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system including posters within the waiting room, information in the practice leaflet and on the 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 five complaints received in the last 12 months and found that these were handled appropriately in line with the practice complaints policy.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. The outcome of complaints was shared in both practice meetings and patient participation group meetings to assess whether any changes in process were needed. We reviewed the minutes and found that no policies had been changed as a result of the outcome of complaints.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's three year strategic business plan. The practice vision and values included preserving and enhancing the practices reputation for being a caring and innovative practice, and committing themselves to providing the highest standard of care and treatment within the financial and building limitations that they faced.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of practice meetings and saw that staff had discussed and agreed that the vision and values were still current.

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 eight policies and procedures including medicines management, infection control, carers and referral policy. All the policies and procedures we looked at 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 the senior partner was the lead for safeguarding There was a named GP governance lead who took responsibility to ensure all aspects of governance was working appropriately. Governance was discussed within clinical meetings and we saw evidence of these discussions. We spoke with six 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 team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. This included prescribing audits, patients with raised ferritin levels and patients on SSRIS (Selective Serotonin Reuptake Inhibitor) and NSAIDS (nonsteroidal Anti-inflammatory Drugs).

The practice had arrangements for identifying, recording and managing risks. The practice had a risk log; risks were discussed within clinical meetings when they arose. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We saw that full team meetings, clinical and administration specific meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings and were happy doing so.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, sickness policy, induction policy, whistleblowing policy and disciplinary procedures which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. We found evidence that policies had been read by staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the annual patient survey, NHS Choices website and through the practice improvement book which was open to both patients and staff. We looked at the results of the annual patient survey and 90% of patients who responded were satisfied with the overall service provided. Patients we spoke with on the day were happy with the practice and spoke positively about the duty doctor system that was implemented by the surgery since the patient survey in 2013. One area identified in the 2014 patient survey was that patients were unaware of the electronic prescribing system available. The practice responded by raising awareness through the practice newsletter, website and

Are services well-led?

Good

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

through information on display within the practice. The practice planned to undertake an audit of patient awareness of the system to see if there was more patient awareness.

The practice had an active patient participation group (PPG). The PPG included thirty three representatives from all the various population groups. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last national patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. The PPG also discussed the bigger issues surrounding the practice and regularly discussed developments within the local community and the local Clinical Commissioning Group (CCG) and how these impacted on the practice. For example how the moving of services from the local hospital would impact patients. The PPG invited guest speakers from hospitals and the CCG to discuss relevant issues of concern or services they provide which could be of benefit to patients at the practice.

The practice had gathered feedback from staff through staff meetings and annual appraisals. Staff told us they felt comfortable giving feedback and discussing any concerns or issues with management. They told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported continued learning and development through training and mentoring. We looked at staff files and found that regular appraisals took place which included a personal development plan. Staffs were openly encouraged to advance themselves through training for internal promotions.

The practice had completed reviews significant events and other incidents and shared the information and outcomes with staff during practice meetings to ensure the practice improved outcomes for patients. For example, following an incident when a trainee was confused over patient's symptoms causing a misdiagnosis, a clinical review took place and the learning was shared with staff through practice meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person failed to ensure that all staff acting as chaperones had received a Disclosure and Barring Service (DBS) check. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.